

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

*Approved by Commissioner*

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH				13007																				
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>					c. LENGTH OF STAY IN lb MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>					b. COUNTY <b>Montgomery</b>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4600 Harlan Road--Aspen Hill</b>										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>					d. STREET ADDRESS <b>4600 Harlan Road-Aspen Hill</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <b>Olivia</b>					First		Middle			Last		4. DATE OF DEATH <b>9/6/66</b>		Month		Day		Year																
5. SEX <b>Female</b>					6. CDLDR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH <b>July 18, 1890</b>		9. AGE (in years last birthday) <b>76</b>		10. IF UNDER 1 YEAR Months <b>yrs.</b>		11. IF UNDER 24 HRS Days		12. IF UNDER 24 HRS Hours		13. IF UNDER 24 HRS Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>																			
13. FATHER'S NAME <b>Frank E. Cummings</b>					14. MOTHER'S MAIDEN NAME <b>Emma</b>																													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>263-96-7306</b>					17. INFORMANT Jean C. Pack 6000 Crawford Drive Rockville, Md. Son					Address																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b>					Coronary occlusion										INTERVAL BETWEEN ONSET AND DEATH <b>short time</b>																			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					DUE TO (c)																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>																																		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, officebldg., etc.)		20f. (City or town) <b>Aug 17, 1966</b>		(County) <b>Sept 1, 1966</b>		(State) <b>1966</b>		20g. (City or town) <b>Silver Spring</b>					(County) <b>Maryland</b>		(State) <b>1966</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 17, 1966</b> to <b>Sept 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>Aug 17, 1966</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above.																																		
22a. SIGNATURE <b>John N. Andrews</b>															22b. DATE SIGNED <b>9-6-66</b>																			
22c. PHYSICIAN'S NAME (Type) <b>John N. Andrews</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>					MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22d. ADDRESS <b>9601 Colesville Road, Silver Spring</b>																			
23a. BURIAL, CREMATION, BONE ASH (specify) <b>Burial</b>					23b. DATE THEREOF <b>9/8/66</b>					23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven</b>					23d. LOCATION (City, town or county) <b>Silver Spring, Montg. Md.</b>																			
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>					25a. REC'D BY REGISTRAR <b>SEP 7 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																								

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temperature

water weight

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

13014

## CERTIFICATE OF DEATH

13008

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.  
 Page 4 may be retained by the hospital or attending physician.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in an event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>2 mo. 1 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. + Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>	
3. NAME OF DECEASED (Type or print) <i>Charles Stewart Parnell</i>		First	Middle
4. DATE OF DEATH Month <i>Sept.</i>		Last	Day <i>12</i>
5. SEX <i>male</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>11-3-96</i>		9. AGE (In years last birthday) <i>69</i>	10. IF UNDER 1 YEAR Months <i>0</i>
11. BIRTHPLACE (County & State, or foreign country) <i>D.C.</i>		12. IF UNDER 24 HRS. Days <i>0</i>	13. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>geologist (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>Wm Parnell</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bennett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>578-50-6065</i>	
17. INFORMANT <i>med. Records - W.S.H.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>		INTERVAL BETWEEN ONSET AND DEATH	
163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) <i>RESPIRATORY DISTRESS</i> DUE TO (c) <i>CA OF THE LUNG</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>METASTASES PROBABLY, URINARY TRACT NURSED</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>PROBABLY, URINARY TRACT NURSED</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>1040M</i>
20f. (City or town) <i>1040M</i>		(County) <i>MD</i>	
20g. (State) <i>MD</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>7-11</i> , 19 <i>66</i> , to <i>9-12</i> , 19 <i>66</i> , that (I) (we) lost sow the deceased alive on <i>9-12</i> 19 <i>66</i> , and that death occurred at <i>1040M</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>9/12/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN L. FORD MD</i>		22d. ADDRESS <i>831 UNIVERSITY BLVD E. SILVER SPRING, MD.</i>	22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/15/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>
24. FUNERAL DIRECTOR, <i>The S.H. Skie Co. Washington, DC</i>		23d. LOCATION (City or Town) <i>SEP 14 1966</i>	(County) <i>Virginia</i>
		23e. ADDRESS <i>2001 14th St. NW</i>	(State) <i>VA</i>
		23f. REC'D BY REGISTRAR <i>Charles J. Charles</i>	23b. REGISTRAR'S SIGNATURE <i>Charles J. Charles</i>

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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13015 CERTIFICATE OF DEATH 13009

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>214 days</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>11 Clement Street</b>		e. STREET ADDRESS								
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>John</b>	Last <b>Patton</b>	4. DATE OF DEATH <b>September 10, 1966</b>	Month <b>September</b>	Day <b>10</b>	Year <b>1966</b>	5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 July 1936</b>	9. AGE (In years last birthday) <b>30 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland-Lonaconing</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>										
13. FATHER'S NAME <b>William B. Patton</b>		14. MOTHER'S MAIDEN NAME <b>Geraldine White</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1954-1958</b>		17. INFORMANT The Medical Records Address <b>The Clinical Center, Bethesda, Maryland</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b>		2041		DUE TO (b) <b>Chronic Myelogenous Leukemia- in Blast crisis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>32 hours</b>								
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (c)		7 Months												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hepatic insufficiency of unknown etiology</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>8 February, 1966</b> , to <b>10 Sept., 1966</b> , that <input type="checkbox"/> (we) last saw the deceased alive on <b>10 Sept., 1966</b> , and that death occurred at <b>8:15M</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Jerry L. Spivak</b>		22b. DATE SIGNED <b>P.M.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. DATE SIGNED <b>11 September 1966</b>								
22c. PHYSICIAN'S NAME (Type) <b>Jerry L. Spivak, MD.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 15, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Restlawn Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Near Cumberland, Md. Allegany</b>						
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>SEP 14 1966</b>		ADDRESS		DATE								







MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13017

CERTIFICATE OF DEATH

13011

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>12 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>13202 Okinawa Avenue</b>		d. STREET ADDRESS <b>13202 Okinawa Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LENA C. PEARSON</b>		First <b>LENA</b>	Middle <b>C.</b>
4. DATE OF DEATH <b>Sept. 30, 1966</b>		Last <b>PEARSON</b>	Month Day Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur Posey</b>		14. MOTHER'S MAIDEN NAME <b>Laura Ennis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-20-1858</b>	
17. INFORMANT <b>Clifford C. Pearson-Husband-Same Item #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial Infarction</b> INTERVAL BETWEEN ONSET AND DEATH 4201 DUE TO (b) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>coronary arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Diabetes Mellitus Hypertension</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>injury</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>809 Viers Mill Rd.</b>
		20f. (City or town) <b>Rockville</b>	(County) <b>Maryland</b>
		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/1/1960</b> to <b>9/29/1966</b> that (I) (we) last saw the deceased alive on <b>9/29/1966</b> and that death occurred at <b>6301</b> M, from causes and on the date stated above.		22b. DATE SIGNED <b>9-30-66</b>	
22a. SIGNATURE <b>Donald L. Bucy</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD L. BUCY</b>		22d. ADDRESS <b>809 Viers Mill Rd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/3/1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn Cemetery</b>
		23d. LOCATION (City or Town) <b>Rockville</b>	(County) <b>Maryland</b>
		(State)	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	25a. RECD BY REGISTRAR <b>Charles Judge</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
			DATE <b>OCT 4 1966</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3-18

CERTIFICATE OF DEATH

13012

**10. HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**10. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Cleared with medical examiner*

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		b. COUNTY	
b. CITY OR TOWN (If a. outside corporate limits, write RURAL and give nearest town) <i>Forest Glen</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <i>726 Richmond Ave.</i>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sylvan Woods Health Care Center</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. NAME OF DECEASED (Type or print) <i>Pet John</i>		First <i>John</i>	Middle <i>Wm</i>
g. NAME OF DECEASED (Type or print) <i>Petersen</i>		Last <i>Petersen</i>	4. DATE OF DEATH Month <i>Sept.</i> Day <i>18</i> Year <i>1966</i>
h. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>8/11/1880</i>		9. AGE (in years last birthday) <i>86 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stationary Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Engineer</i>	
10c. BIRTHPLACE (County & State, or foreign country) <i>Denmark</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
12. FATHER'S NAME <i>Not available</i>		13. MOTHER'S MAIDEN NAME <i>Not available</i>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		15. SOCIAL SECURITY NO. <i>577-10-8961</i>	
16. INFORMANT <i>Carl A. Petersen (same as #2)</i>		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>generalized AS, ASHD.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4500</i> (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Hip fracture approx 3 mo before death.</i>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.) <i>fell at home</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>10 - 5-166</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>S.S. Mont Md.</i> (County) <i>(Same)</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>6-1</i> , 19 <i>66</i> , to <i>9-18-66</i> , that (I) (we) last saw the deceased alive on <i>9-1 1966</i> and that death occurred at <i>8:30 P.M.</i> from causes and on the date stated above.		22. DATE SIGNED <i>9-18-66</i>	
22a. SIGNATURE <i>S. J. Englehardt M.D.</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>S. J. Englehardt M.D.</i>		22d. ADDRESS <i>924, Columbia Blvd. Silver Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 21, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Congressional Cemetery</i>		23d. LOCATION (City or Town) <i>Washington</i> (County) <i>D.C.</i> (State) <i>(Same)</i>	
24. FUNERAL DIRECTOR ADDRESS <i>254 Carroll St. N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 22 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13013

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Montgomery</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Salisbury</i>		<i>6 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
<i>Washington Sanitorium Hospital</i>		<i>6426 Knollbrook Drive</i>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Hugh Atkins Poore</i>		<i>Hugh</i>	<i>Atkins</i>
4. DATE OF DEATH		Month	Day Year
<i>September 16, 1966</i>		<i>September</i>	<i>16</i> <i>1966</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<i>Male</i>		<i>White</i>	<i>WIDOWED</i> <input type="checkbox"/> <i>DIVORCED</i> <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR / UNDER 24 HRS
<i>January 11 1913</i>		<i>53</i> yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Teacher</i>		<i>Industry</i>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<i>Virginia</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S M AIDEN NAME	
<i>Robert Poore</i>		<i>Patricia</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
<i>No</i>		<i>217-05-5594 Hospital Records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cirrhosis of the liver with ascites</i>	
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		<i>(b)</i>	
DUE TO		<i>(c)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
<i>19</i>		<i>at work</i> <input type="checkbox"/> <i>at work</i> <input type="checkbox"/>	<i>Hyattsville</i> <i>Maryland</i> <i>Maryland</i>
21. I certify that (I) (this hospital) attended the deceased from <i>9-7</i> , 19 <i>66</i> , to <i>9-16</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9-5</i> 19 <i>66</i> , and that death occurred at <i>6426 Knollbrook Drive</i> M, from the causes and on the date stated above.		22b. DATE SIGNED <i>9-16-66</i>	
22a. SIGNATURE <i>Ronald S. Fleischer</i>		22b. DATE SIGNED <i>9-16-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>RONALD S. FLEISCHER</i>		22d. ADDRESS <i>7411 Riggs Rd. Hyattsville, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 19, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>
24. FUNERAL DIRECTOR <i>Garth Weller</i>		25a. ADDRESS <i>254 Carroll St. NW</i>	25b. REC'D BY REGISTRAR <i>Charles Judge</i>
25c. DATE <i>SEP 13 1966</i>		25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH					
13020			13014		
<p>1. PLACE OF DEATH            a. COUNTY <u>Montgomery</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u></p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u></p>			<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)            a. STATE <u>XXXXXX</u></p> <p>b. COUNTY</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u></p> <p>d. STREET ADDRESS <u>3355 - 16th St. N. W.</u>            Apt. 201</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		
<p>3. NAME OF DECEASED First <u>Nellie</u> Middle <u>W.</u> Last <u>Powell</u></p>			<p>4. DATE OF DEATH Month <u>Sept</u> Day <u>1</u> Year <u>1966</u></p>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 3, 1876</u>	9. AGE (In years lost birthday) <u>90 yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u></p>			<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u></p>		
<p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>Kingston, Pa.</u></p>			<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		
<p>13. FATHER'S NAME <u>George Kellogg Powell</u></p>			<p>14. MOTHER'S MAIDEN NAME <u>Haretta Linsell</u></p>		
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u></p>			<p>16. SOCIAL SECURITY NO.</p>		
<p>17. INFORMANT <u>Nursing Home Records same as #1</u></p>			<p>Address</p>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Carcinoma of Lung with</u> DUE TO <u>Generalized Metastases</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 yrs</u></p> <p>113X</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)</p>					
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)</p>					
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p>			<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>		
<p>20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u></p>			<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>		
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>			<p>20f. (City or town) <u>Forty Ft. Pennsylvania</u> (County) <u>Pennsylvania</u> (State)</p>		
<p>21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u>, 19<u>65</u>, to <u>Sept 1</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>Aug 31</u>, 19<u>66</u>, and that death occurred at <u>4:30 AM</u>, from causes and on the date stated above.</p>					
<p>22a. SIGNATURE <u>Theodore J. Abernethy</u></p>			<p>22b. DATE SIGNED <u>9-1-66</u></p>		
<p>22c. PHYSICIAN'S NAME (Type) <u>Theodore J. Abernethy, M.D.</u></p>			<p>22d. ADDRESS <u>916-19th St. N.W. Washington D.C.</u></p>		
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u></p>			<p>23b. DATE THEREOF <u>9/3/66</u></p>		
<p>23c. NAME OF CEMETERY OR CREMATORIAL</p>			<p>23d. LOCATION (City or Town) (County) (State)</p>		
<p>24. FUNERAL DIRECTOR <u>The S. H. Hines</u></p>			<p>ADDRESS <u>Washington DC</u></p>		
<p>25a. REC'D. BY REGISTRAR DATE <u>SEP 3 1966</u></p>			<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>		



1 M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13015

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE	
Montgomery Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. & Hospital		d. STREET ADDRESS 8606 11th Ave	
3 NAME OF DECEASED (Type or print) Annie		First	Middle
3 NAME OF DECEASED (Type or print) Annie		Last	4 DATE OF DEATH Sept. 27 1966
S. SEX Female	6 COLOR OR RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Lithuania		9. AGE (in years last birthday) 80 yrs	
12. CITIZEN OF WHAT COUNTRY United States		10. IF UNDER 1 YEAR Months Days Hours Min	
13. FATHER'S NAME Abraham Siegel		14. MOTHER'S MAIDEN NAME Rose Katz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) f201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: coronary occlusion			
DUE TO (b) coronary occlusion DUE TO (c) Cardio-Vascular Disease - Severe.			
INTERVAL BETWEEN ONSET AND DEATH Recent.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of RT. Hip.			
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell in Nursing Home.	
20c. TIME OF INJURY Month, Day, Year Hour o m 7 p m 9/18 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home form, factory, street, office bldg., etc.) Nursing Home.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		20f. (City or town) (County) (State) Silver Spring Mont. Md.	
ACTUAL SIGNATURE John S. Ball MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 9/27/66	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/28/66	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hebron Cem.
24. FUNERAL DIRECTOR B. Damjanich & Sons		ADDRESS 3501-14th St. NW	25a. RECEIVED BY REGISTRAR DATE SEP 23 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



1 M  
FOR STATE  
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

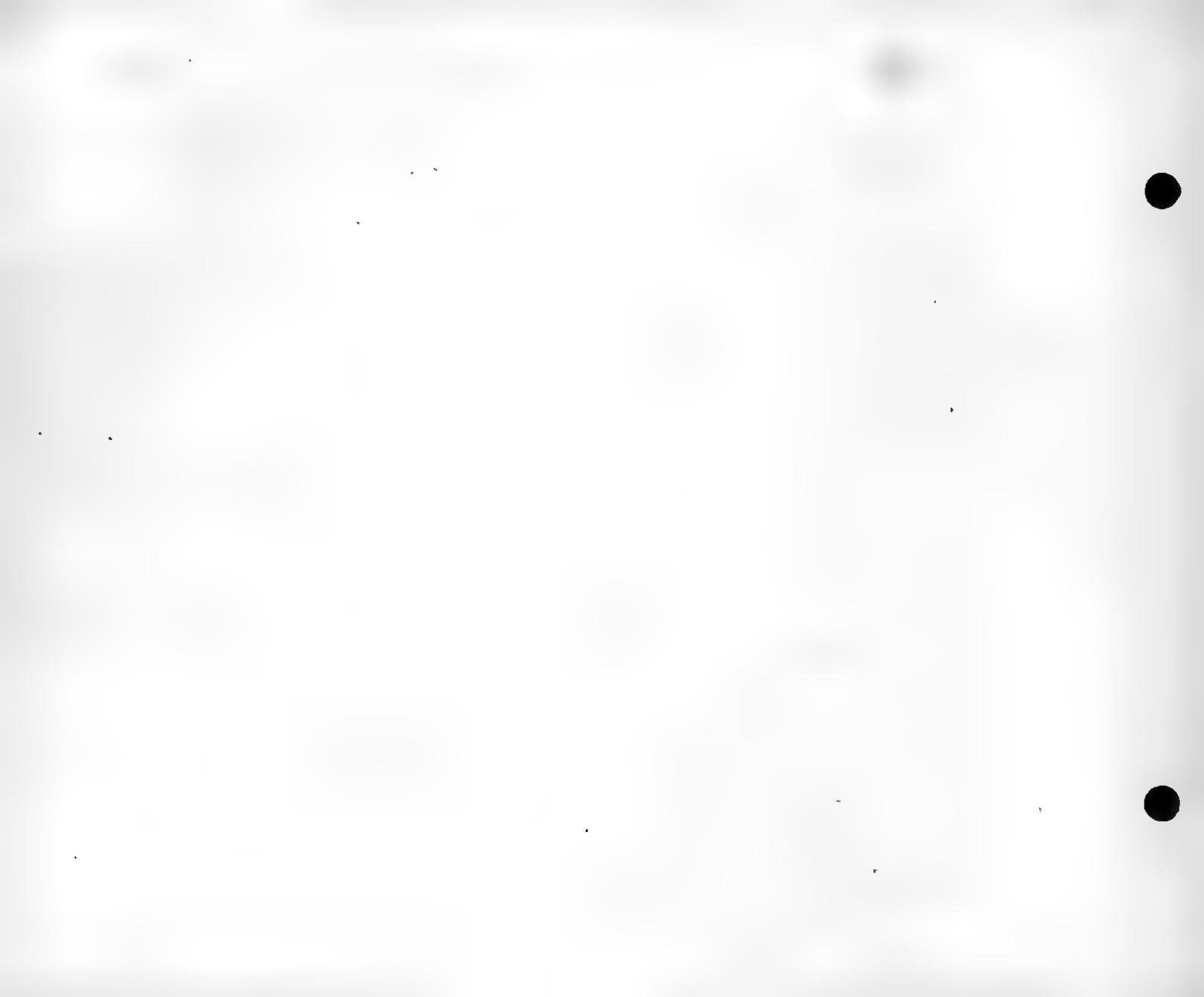
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1, 2, and 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in one copy, within 72 hours after death.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13016

PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
a. COUNTY <u>Montgomery</u>		a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		b. COUNTY <u>Ge. Geo.</u>	
c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		d. STREET ADDRESS <u>7509 Jackson Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>CHESTER</u>	Middle <u>WILLIAM</u>	Last <u>RAUCH</u>
4. DATE OF DEATH	Month <u>9</u>	Day <u>30</u>	Year <u>1966</u>
S. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>5-20-06</u>
9. AGE (In years last birthday) <u>60</u>	10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Irving Rauch</u>		
14. MOTHER'S MAIDEN NAME <u>Carolina</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO	17. INFORMANT <u>The. David J. Lawrence</u>	Address <u>2290 Frederick Rd. #2. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute asphyxiation due to</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1 x 1.5</u> <u>massive aspiration of gastric contents</u> DUE TO (b) <u>massive aspiration of gastric contents</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Deceased vomited and aspirated vomitus.</u>			20c. TIME OF INJURY Month, Day, Year Hour am <u>7:15 pm 9-30 1966</u>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Street</u>
20f. (City or town) <u>Hyattsville</u>			(County) <u>Pr. Geo.</u>
(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Lepp</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>BELDEN R. LEPP M.D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) <u>Penna.</u>
22. DATE SIGNED <u>9-30-1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct. 3-1966 Valley Forge Cremation</u>	23b. DATE THEREOF <u>Oct. 3-1966</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Valley Forge Cremation</u>	23d. LOCATION (City or Town) <u>Penna.</u>
23e. (County) <u>Pr. Geo.</u>	(State) <u>Md.</u>		
24. FUNERAL DIRECTOR <u>Arthur Taltas</u>	254 ADDRESS <u>254 Carroll St.</u>	25a. REC'D BY REGISTRAR <u>Charles J. Gegeen</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Gegeen</u>
DATE <u>OCT 3 1966</u>		DATE <u>OCT 3 1966</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3 23

CERTIFICATE OF DEATH

13013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE	
Montgomery		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 6 days	
BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Suburban Hospital		1034 Welsh DRIVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Richard M. Ream		Last	4. DATE OF DEATH
5. SEX		5. COLOR OR RACE	
MALE		6. COLOR OR RACE	
White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH	
Died 8/26/66		9. AGE (In years last birthday)	
Dir. of Transp.		10. KIND OF BUSINESS OR INDUSTRY	
Mont. Co. Schools		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Addison Carl Ream		14. MOTHER'S MARRIED NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
Yes		579-24-4670	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
Doris E. Ream		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
Wife		Osteosarcoma metastasis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from Feb 18, 1966, to 16 Sept, 1966, that (I) (we) last saw the deceased alive on 16 Sept, 1966, and that death occurred at 8:30A M, from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
Joseph F. Schanno		16 Sept 66	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	
JOSEPH F. SCHANNO		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
9-19-66		Parklawn Cemetery	
24. FUNERAL DIRECTOR		23d. LOCATION (City, town or county) (State)	
ROBERT A. PUMPHREY, Bethesda, Maryland		Rockville, Maryland	
VR A15 (4) 15M 4-64		25a. REC'D BY REGISTRAR	
J. Charles Judge		25b. REGISTRAR'S SIGNATURE	
DATE SEP 20 1966			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 (M)

324

## CERTIFICATE OF DEATH

13018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN b <b>19 hrs 20 min</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASH SANITARIUM &amp; HOSP</b>		e. STREET ADDRESS <b>New Hampshire Ave. 10110</b>		
3. NAME OF <b>CORA M. REAMY</b> (Type or print)		4. DATE OF DEATH <b>9 10 19 66</b>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX <b>F</b>	7. COLOR OR RACE <b>W</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <b>11-16-88</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>VA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BUSHROD MINOR</b>		14. MOTHER'S MAIDEN NAME <b>ALTHEA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO <b>None</b>	17. INFORMANT <b>John T. Reamy</b>	18. ADDRESS <b>1508 Quebec St. Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>190X</b>				
DUE TO (b) <b>Pneumonia, acute, type undetermined</b>				
DUE TO (c) <b>Fat</b>				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Right degeneration of heart</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>None</b>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Suitland</b>	(County) (State) <b>Maryland</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 10, 1966</b> to <b>Sept 11, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 11, 1966</b> , and that death occurred at <b>9-11-66</b> M, from causes and on the date stated above.				
22a. SIGNATURE <b>W. W. Eastman</b>		22b. DATE SIGNED <b>9-11-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>W. W. Eastman</b>		22d. ADDRESS <b>831 University Blvd., S. S., Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sep. 13, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) <b>Suitland, Maryland</b>	(County) (State)
24. FUNERAL DIRECTOR <b>Glen Carter Crematorium Warren E. Pumphrey, Inc.</b>		25a. ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>	25b. REC'D BY REGISTRAR <b>SEP 14 1966</b>	25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

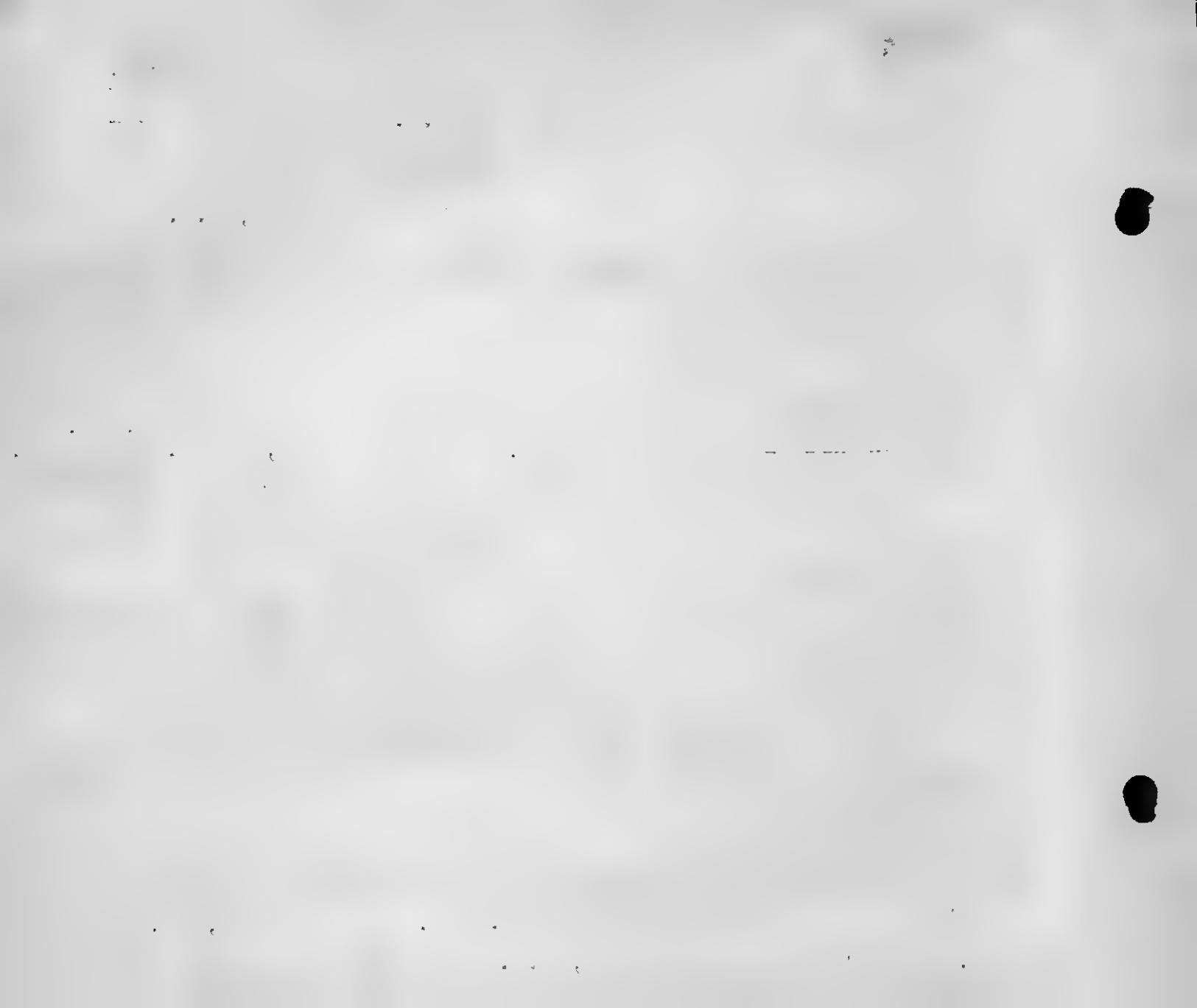
## CERTIFICATE OF DEATH

13019

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE <i>D.C.</i> b. COUNTY <i>... .</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. LENGTH OF STAY IN 1b <i>MARYLAND</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Wheaton Nursing Home 11901 Georgia Ave.</i>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
3. NAME OF DECEASED (Type or print) <i>Bessie</i>		f. STREET ADDRESS <i>3201 Woodley Road, N.W.</i>	
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		g. DATE OF DEATH Last Month Day Year <i>9 23 1966</i>	
5. SEX <i>Female</i>		h. DATE OF BIRTH Last Month Day Year <i>12-21-83</i>	
6. COLOR OR RACE <i>White</i>		i. AGE (In years last birthday) If UNDER 1 YEAR Months Days Hours Min. <i>88 yrs.</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		j. BIRTHPLACE (County & State, or foreign country) <i>Iowa</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Park</i>		14. MOTHER'S MAIDEN NAME <i>Anna Bowerman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>... .</i> Mrs. Annis Burroughs, 3232 N. Woodson St. Arlington, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CEREBRAL VASCULAR THROMBOSIS</i> Conditions, if any, which gave rise to immediate cause (b) <i>DIABETIS MELLITUS</i> (c) <i>... .</i>		INTERVAL BETWEEN ONSET AND DEATH <i>IMMED.</i> MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 1965</i> to <i>Sept 23, 1966</i> , that (I) (we) last saw the deceased alive on <i>22 Sept 1966</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.			
22e. SIGNATURE <i>Walter Goosby</i>		22b. DATE SIGNED <i>... .</i>	
22c. PHYSICIAN'S NAME (Type) <i>WALTER GOOSBY</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS <i>2390 GLENMONT CIR WHEATON MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/27/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Arlington Nat. Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Arlington, Va.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jos. Gawler's Sons, Washington, D.C.</i>		25e. REC'D BY REGISTRAR DATE <i>SEP 27 1966</i> <i>... .</i> 25b. REGISTRAR'S SIGNATURE <i>... .</i>	



16-1326  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLANDCERTIFICATE OF DEATH  
13020

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>10 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10703 Lorain Avenue</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. STREET ADDRESS <i>10703 Lorain Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Leonora</i>		First <i>Cecelia</i>	Middle <i>Reed</i>
4. DATE OF DEATH <i>September 8</i>	Month <i>September</i>	Day <i>8</i>	Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>March 11, 1903</i>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		9. AGE (in years last birthday) <i>63</i> yrs.	
10a. KIND OF BUSINESS OR INDUSTRY <i>U. S. Govt.</i>		10b. BIRTHPLACE (State or foreign country) <i>Portsmouth, Virginia</i>	
11. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		12. FATHER'S NAME <i>Oscar W. Reed, Sr.</i>	
13. MOTHER'S MAIDEN NAME <i>Isabel S. Miller</i>		14. INFORMANT <i>Oscar W. B. Reed, Jr. Silver Spring, Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  DUE TO  (b)  DUE TO  (c)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <i>Intestinal obstruction</i>	
		19. INTERVAL BETWEEN ONSET AND DEATH <i>4 day</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1 1966</i> to <i>Sept 8 1966</i> that (I) (we) last saw the deceased alive on <i>Sept 6 1966</i> , and that death occurred at <i>5th M.</i> from the causes and on the date stated above.		22b. DATE 5 GNED	
22a. SIGNATURE <i>E. G. Quayle</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS <i>1833 Biltmore St NW Washington DC</i>
22c. PHYSICIAN'S NAME (Type) <i>F. B. Quayle M.D.</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE THEREOF <i>Sep. 10, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt. Olivet Cemetery</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Clark E. Wison</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 13 1966</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Pumphrey, Inc.</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

1302

<p>1 PLACE OF DEATH a. COUNTY <b>Montgomery</b></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b></p> <p>c. LENGTH OF STAY IN IB <b>D.O.A.</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b></p>				<p>2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b></p> <p>b. COUNTY <b>Montgomery</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b></p> <p>d. STREET ADDRESS <b>8615 Mayfair Pl.</b></p>			
<p>3 NAME OF DECEASED (Type or print) <b>Endel Rennit</b></p> <p>First <b>Endel</b> Middle <b>Rennit</b> Last <b></b></p>				<p>4 DATE OF DEATH <b>5, Sept, 66</b></p> <p>Month <b>Sept</b> Day <b>5</b> Year <b>1966</b></p>			
<p>5 SEX <b>Male</b></p>		<p>6 COLOR OR RACE <b>White</b></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>4-30-1911</b></p>	
<p>10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Producer &amp; Writer</b></p>		<p>10b KIND OF BUSINESS OR INDUSTRY <b>- - -</b></p>		<p>11 BIRTHPLACE (County &amp; State, or foreign country) <b>Estonia</b></p>		<p>12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>Unknown</b></p>				<p>14. MOTHER'S MAIDEN NAME <b>Unknown</b></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</p>		<p>16. SOCIAL SECURITY NO. <b>- - -</b></p>		<p>17. INFORMANT <b>Esther Rennit - See Item No. 2</b></p>		<p>Address</p>	
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY</p> <p>IMMEDIATE CAUSE (a) <b>coronary occlusion</b></p> <p>420.1 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic heart disease</b></p> <p>420.1 DUE TO</p> <p>(c) <b></b></p> <p>INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b></p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p><b>NO</b></p>							
<p>20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) <b></b> (County) <b></b> (State) <b></b></p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <b>15-60</b>, 19<b>66</b>, to <b>9-3</b>, 19<b>66</b>, that (I) (we) last saw the deceased alive on <b>5-31-66</b>, 19<b>66</b>, and that death occurred at <b>9:30 P.M.</b>, from causes and on the date stated above.</p>							
<p>22a. SIGNATURE <b>Veronica Troost</b></p>				<p>22b. DATE SIGNED <b>9-5-1966</b></p>			
<p>22c. PHYSICIAN'S NAME (Type) <b>VERONIKA TROOST</b></p>		<p>22d. ADDRESS <b>10236, N. H. Ave., Silver Spring, Md.</b></p>					
<p>23a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b></p>		<p>23b. DATE THEREOF <b>9-10-1966</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Crematory</b></p>		<p>23d. LOCATION (City or Town) <b>Suitland, Md.</b> (County) <b></b> (State) <b></b></p>	
<p>24. FUNERAL DIRECTOR <b>Joseph Gowers Sons</b></p>		<p>ADDRESS <b>WASH. D.C.</b></p>		<p>25a. RECD. BY REGISTRAR <b>Charles Judge</b></p>		<p>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

cleared with medical examiner / mgd

VR A15 14  
20 M 1/6

130



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Deceased by M. Dobridge*

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13-28

CERTIFICATE OF DEATH

13-28

1 PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>			2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		
d. NAME OF DECEASED (Type or print) <i>FRANCES</i>			First <i>FRANCES</i>	Middle <i></i>	Last <i>ROBBINS</i>
3 SEX <i>FEMALE</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED WIDOWED <i></i>	8 NEVER MARRIED DIVORCED <i></i>	9 DATE OF BIRTH <i>9/13/1977</i>	10 AGE (In years last birthday) <i>69 yrs</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY <i></i>		11 BIRTHPLACE (County & State, or foreign country) <i>New York</i>	
13 FATHER'S NAME <i>ISRAEL Siegerman</i>			14 MOTHER'S MAIDEN NAME <i>JENNIE</i>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16 SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Marye &amp; Robbins</i>	Address <i>Same as 20</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Arteriosclerosis</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1966</i> to <i>Sept 20, 1966</i> , that (I) <input type="checkbox"/> last saw the deceased alive on <i>Sept 20, 1966</i> , and that death occurred on <i>Sept 20, 1966</i> , from causes and on the date stated above					
22a. SIGNATURE <i>Michael Dobridge</i>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>Michael Dobridge</i>			22d. ADDRESS <i>12600 Park Rd. Rockville Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-21-66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Seth David Cem.</i>	
24. FUNERAL DIRECTOR <i>GOLDBERG FUNERAL HOME</i>		ADDRESS <i>4217 - 95-17-184</i>		25a. REC'D. BY REGISTRAR DATE <i>SEP 22 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>W. Goldsby Judge</i>					



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13023

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		
Montgomery MARYLAND		b. COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE		
c. LENGTH OF STAY IN 1b 14 hours		d. STREET ADDRESS 13014 FREELAND ROAD		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First MAURICE	Middle Joseph	Last ROCHE	
4. DATE OF DEATH	Month 9	Day 2	Year 1966	
5. SEX MALE	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/02	
9. AGE (in years last birthday) 62 yrs.	10. KIND OF BUSINESS OR INDUSTRY Naval X X X O. Laboratory	11. BIRTHPLACE (County & State, or foreign country) IRELAND	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Roche	14. MOTHER'S MAIDEN NAME Catherine Martine	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO.		17. INFORMANT		
None		Anna Catherine Roche Rockville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4331 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
DUE TO (b) ATRIAL FIBRILLATION DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DIS.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1963, to 9-1-1966, that (I) (we) last saw the deceased alive on 9-1-1966, and that death occurred at 826A M, from the causes and on the date stated above.		22b. DATE SIGNED		
22a. SIGNATURE WALTER E. GLOOR MD		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 230 GLENMONT CIR WHEATON MD	
22c. PHYSICIAN'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
		23b. DATE THEREOF Sept. 6, 1966		
		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery		
24. FUNERAL DIRECTOR Clark E. Wiso 8434 Georgia Ave.		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland		
		25a. REC'D BY REGISTRAR Charles Judge		
		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13030 CERTIFICATE OF DEATH 13024

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> LENGTH OF STAY IN 1b 29 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>			d. STREET ADDRESS <b>7424 Bethune Street</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) <b>Ivan</b>			First	Middle	Last		
			4 DATE OF DEATH <b>September 29 1966</b>				
5. SEX <b>Male</b>			6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>6 May 1893</b>		
			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>73 yrs</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Doctor</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Poltara, Ukraine</b>			
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ivan ROMANENKO</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>560 42 7470</b>				
17. INFORMANT <b>Charles C. SPOONER Jr. for 7424 Bethune St. Mrs. Fekla P. ROMANENKO</b>			18. ADDRESS <b>Falls Church, Va.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Encephalopathy</b>			19. INTERVAL BETWEEN ONSET AND DEATH				
18.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
18.2 DUE TO (b) _____							
18.3 DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <b>(this hospital)</b> attended the deceased from <b>31 August, 1966</b> , to <b>29 September 1966</b> that <b>(we)</b> last saw the deceased alive on <b>29 September 1966</b> , and that death occurred at <b>3:45 PM</b> , from causes and on the date stated above						22b. DATE SIGNED <b>1966</b>	
22a. SIGNATURE <b>John C. Baxter, LCDR</b>			M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>29 September</b>		
22c. PHYSICIAN'S NAME (Type) <b>J. C. BAXTER, LCDR MC USN</b>			22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			23b. DATE THEREOF <b>10/3/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>		
24. FUNERAL DIRECTOR Fallen Church Funeral Home			25a. ADDRESS <b>1102 West Broad St. Falls Church, Virginia</b>	25a. REC'D BY REGISTRAR <b>OCT 5 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Ward, Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 (M)  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13025

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 to FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 4 hrs 32 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San + Hospital		d. STREET ADDRESS 8309 Garland Ave #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Sept 5 1966	
3 NAME OF DECEASED (Type or print) William Frederick Dale Roudabush		First	Middle
4 DATE OF DEATH Sept 5 1966		Month	Day
5 SEX Male		6 COLOR OR RACE White	7 MARRIED WIDOWED
8 DATE OF BIRTH 8-16-36		9 AGE (In years last birthday) 30 yrs	10 IF UNDER 1 YEAR Months
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic		10b. KIND OF BUSINESS OR INDUSTRY D.C. Dept of Highways	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dale Roudabush		14. MOTHER'S MAIDEN NAME Clarkstown Iona Deal	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 317-38-2045	
17. INFORMANT Betty J. Watson 13016 Georgetown, D. C. Md.		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	
		(b) DUE TO forehead, apparently (c) self - inflicted	
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Deceased shot self in head	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Deceased shot self in head	
20c. TIME OF INJURY Month Day, Year 10:30 a.m. 9-5 1966		20d. INJURY OCCURRED Wh e <input type="checkbox"/> not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Takoma Park	
20g. (County) Montgomery, Md.		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED Sept. 5, 1966	
ACTUAL SIGNATURE BELDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Belden R. Reap M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
REPLACEMENT EXAMINER Address (Street, City, Town, County)		REPLACEMENT EXAMINER Address (Street, City, Town, County)	
23a. BURIAL, CREMATION REMOVAL (Specify) Removal		23b. DATE THEREOF 9/7/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) Scottsburg, Indiana	
24. FUNERAL DIRECTOR The S. H. Hines		25a. RECD BY REGISTRAR DATE SEP 8 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	
Washington, D.C.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

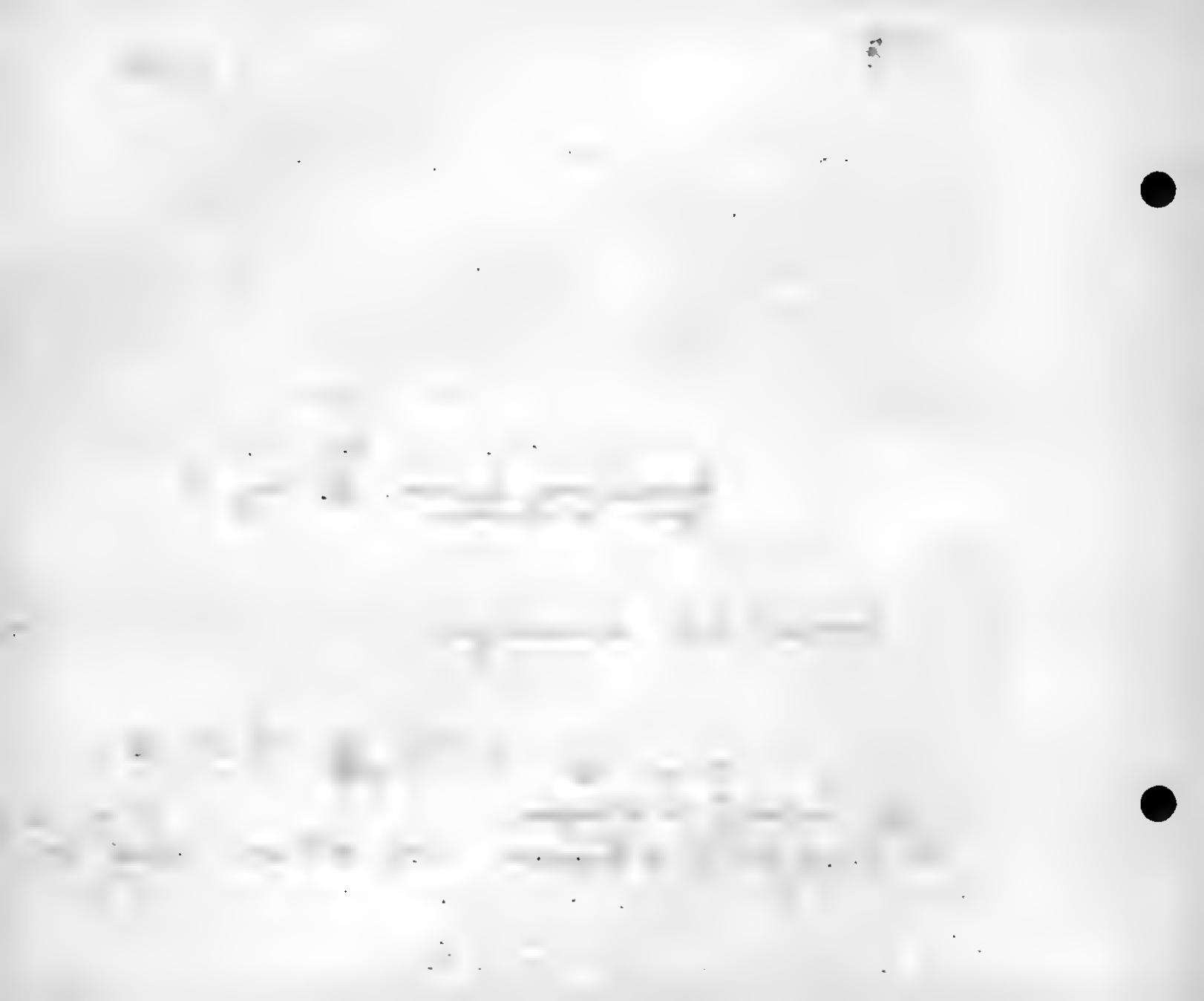
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13026

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Maryland	
c. LENGTH OF STAY IN 1b 3 weeks		d. STREET ADDRESS SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Bartholomew	Middle Miles	Last Ryan
4. DATE OF DEATH	Month SEPTEMBER	Day 21	Year 1966
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIOOWEO <input type="checkbox"/>	8. DATE OF BIRTH 6/9/05
9. AGE (in years last birthday)	10. KIND OF BUSINESS OR INDUSTRY Broker - Al	11. BIRTHPLACE (County & State, or foreign country) Meat Broker	12. CITIZEN OF WHAT COUNTRY U.S.A.
61 yrs.	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14. MOTHER'S MAIDEN NAME Bertha Thompson	
Broker - Al		MASS.	
13. FATHER'S NAME John Ryan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> None	
		16. SOCIAL SECURITY NO. 578-09-5220	
		17. INFORMANT Mrs. Floy C. Ryan	
		Address 95 East Wayne Ave. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621		Bronchogenic carcinoma (b) lung gen. metastasis (c)	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Terminal G.I.T. hemorrhage			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-30, 1966 to 9-21, 1966, that (I) (we) last saw the deceased alive on 9-21, 1966, and that death occurred at 12:00 PM, from the causes and on the date stated above.		22d. DATE SIGNED 9-21-66	
22a. SIGNATURE J.W. Lubeddy Jr. / V. de Gruymer, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. PHYSICIAN'S NAME (Type) J.W. Lubeddy Jr. / V. de Gruymer		22d. ADDRESS 1234 19th N.W. Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sep. 24, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) Prince Georges Co., Md. (State)	
24. FUNERAL DIRECTOR C. Glen Carter		ADDRESS 8434 Georgia Ave.	
Warner E. Murphy, Inc.		25a. REC'D BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. **Page 3**, please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<p><b>1. PLACE OF DEATH</b>            a. COUNTY <b>Montgomery</b>            MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  <b>Tekoma Park</b></p> <p>c. LENGTH OF STAY IN lb  <b>7 days</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  <b>Washington Sanitarium and Hospital</b></p>		<p><b>2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)</b>            a. STATE <b>Maryland</b>            b. COUNTY <b>Montgomery</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  <b>Silver Spring</b></p> <p>d. STREET ADDRESS  <b>507 Dartmouth Avenue</b></p> <p>e. IS RESIDENCE ON A FARM?            YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>						
3. NAME OF DECEASED <small>(Type or print)</small> <b>Mr. John Thomas Ryder</b>		First Middle Last	4. DATE OF DEATH Month <b>September</b> Day <b>19</b> Year <b>1966</b>					
5. SEX	6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
<b>Male</b>	<b>white</b>	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	<b>1905</b> <del>July 24 1905</del>	<b>61</b> yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Manager</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Army times Pub. Co. Ohio</b>			11. BIRTHPLACE (County & State or foreign country) <b>U. S. A. American</b>		
13. FATHER'S NAME <b>Charles M. Ryder</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ralston</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>(Yes, no, or unknown)</small> <b>yes</b>			16. SOCIAL SECURITY NO. <b>276-10-6168</b>			17. INFORMANT <b>Violet E. Ryder</b> <del>XXXXXXXXXX</del> Address <b>507 Dartmouth Ave.</b> <b>Silver Spring, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <small>PART I. DEATH WAS CAUSED BY</small> <small>IMMEDIATE CAUSE (a)</small> <small>1528</small> <small>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.</small>			<b>Metastatic carcinoma of liver</b>			INTERVAL BETWEEN ONSET AND DEATH <small>unknown</small>		
(b)			<b>Primary carcinoma of colon</b>			<small>unknown</small>		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(If either, notify medical examiner)</small>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <small>Hour o.m.</small> <small>p.m.</small> <b>19</b>			20d. INJURY OCCURRED <small>White <input type="checkbox"/> Not White <input type="checkbox"/></small> <small>at work <input type="checkbox"/> at work <input type="checkbox"/></small>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 12, 1966</b> , to <b>Sept 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 13, 1966</b> , and that death occurred at <b>150 AM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>Eino Magi</b>			M.D. <input checked="" type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>EINO MAGI</b>			22d. ADDRESS <b>831 University Blvd. E., Silver Sp., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sep. 21, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cen.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>		ADDRESS <b>Glen Carter 8434 Georgia Ave.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
20 M. 1/66		DATE <b>SEP 27 1966</b>						



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

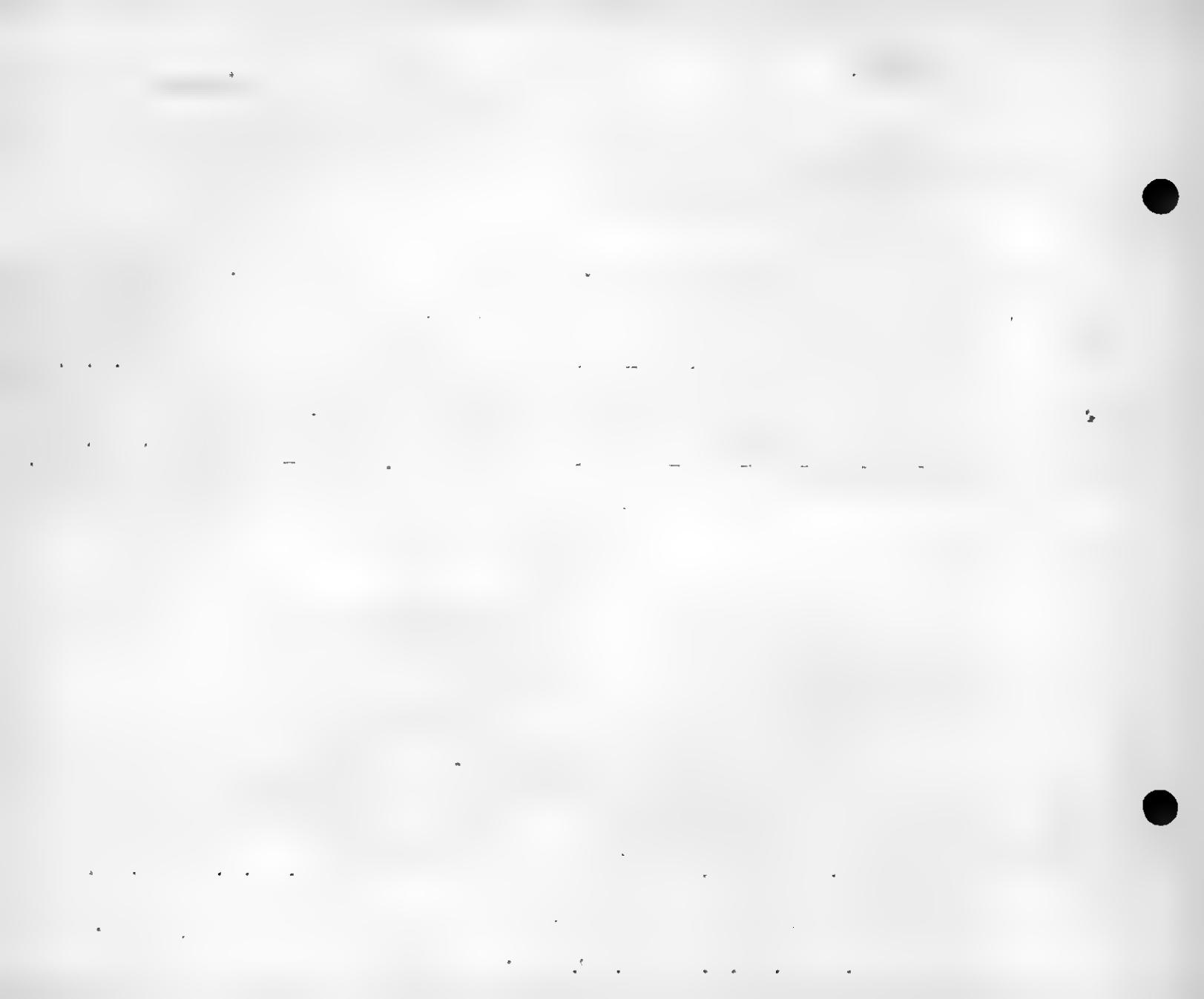
13034

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Chevy Chase</b>		d. STREET ADDRESS <b>4119 Rosemary Street</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4119 Rosemary Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First <b>CLARE</b>	Middle <b>W.</b>	Last <b>STAFFORD</b>	4. DATE OF DEATH Month <b>Sept.</b>	Day <b>14,</b>	Year <b>19 66</b>						
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-30-1868</b>	9. AGE (In years last birthday) <b>97 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	12. IF UNDER 24 HRS Min. <b>0</b>				
10a. US. & AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>— — —</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Decius Wade</b>					14. MOTHER'S MAIDEN NAME <b>Bernice Galpin</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>— — —</b>		17. INFORMANT <b>Bernice S. Pratt</b>		Address <b>Chevy Chase, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY X IMMEDIATE CAUSE (a) <i>Gastrointestinal Bleeding</i>					INTERVAL BETWEEN ONSET AND DEATH <b>one day</b>								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Unknown cause.</b>					(b) <i>Unknown cause.</i>								
DUE TO (c) <i>Unknown cause.</i>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>— — —</b>										
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>— p.m. 19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) <b>—</b>		(County) <b>—</b>		(State) <b>—</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>66</b> , to <b>13 Sept 1966</b> that (I) (we) last saw the deceased alive on <b>13 Sept 1966</b> and that death occurred at <b>3A M</b> , from causes and on the date stated above.								22b. DATE SIGNED <b>14 Sept. 1966</b>					
22a. SIGNATURE <b>David R. Lawrence</b>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>14 Sept. 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. David R. Lawrence</b>					22d. ADDRESS <b>2001 Eye St. N.W. Wash.D.C.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE THEREOF <b>9-16-1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Grand View Cemetery</b>			23d. LOCATION (City or Town) <b>Chillicothe</b>		(County) <b>Ohio</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>			ADDRESS <b>5130 Wisc. Ave. N.W. Wash.D.C.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
DATE <b>SEP 19 1966</b>													



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13 35

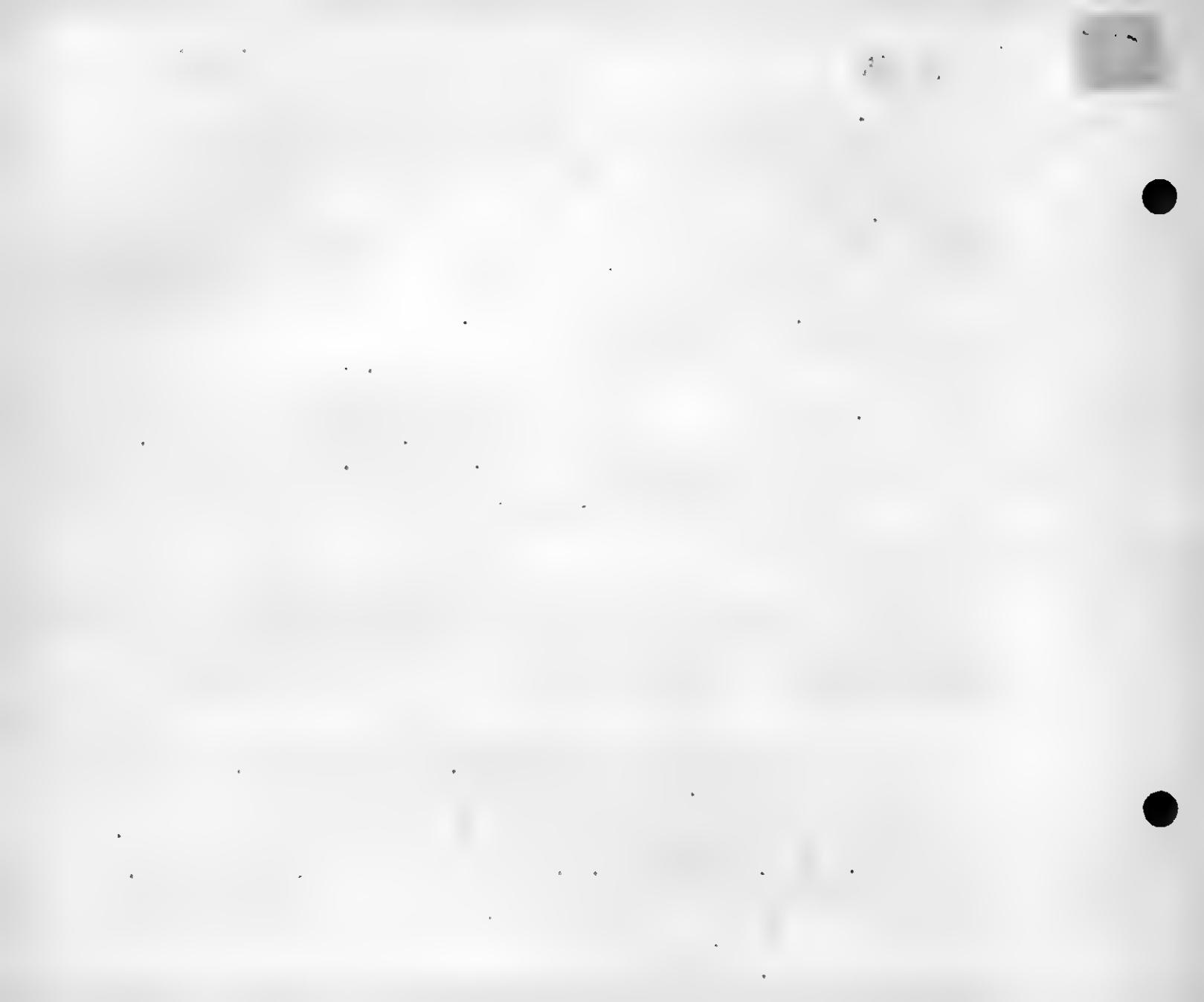
CERTIFICATE OF DEATH

13029

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>1812 Mc Auliffe Drive</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3 NAME OF DECEASED (Type or print) <b>Douglas</b>		First <b>Douglas</b>	Middle <b>Lee</b>	Last <b>SANDERS</b>	4 DATE OF DEATH <b>September 15</b>	Month <b>September</b>	Day <b>15</b>	Year <b>1966</b>		
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc.</b>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 12, 1966</b>	9 AGE (in years lost birthday) yrs <b>3</b>	10 IF UNDER 1 YEAR Months <b>3</b>	11 IF UNDER 24 HRS Days <b>0</b>	12 Hours <b>0</b>		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>			10b KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			11 BIRTHPLACE (County & State or foreign country) <b>Bethesda, Montgomery, Md.</b> 12 CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13 FATHER'S NAME <b>Richard L. Sanders</b>				14 MOTHER'S MAIDEN NAME <b>Shirley Luckett</b>						
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b>			16. SOCIAL SECURITY NO. <b>None</b>		17 INFORMANT <b>Dr. Rockville</b> Address <b>Md.</b> <b>Mr. Richard L. Sander, 1812 Mc Auliffe</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive Subarachnoid Hemorrhage</b>								INTERVAL BETWEEN ONSET AND DEATH		
7600 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)								DUE TO DUE TO DUE TO		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Arlington</b> (County) <b>Virginia</b> (State)			
21. I certify that (b) (this hospital) attended the deceased from <b>Sept. 12, 1966</b> to <b>Sept. 15, 1966</b> that (1) (we) last saw the deceased alive on <b>Sept. 15, 1966</b> , and that death occurred at <b>735 P.M.</b> from causes and on the date stated above.								22b. DATE SIGNED <b>Sept. 16, 1966</b>		
22a. SIGNATURE <i>Jerry J. Tomasovic</i>			M.D. <input type="checkbox"/> ATTENDING PHYS		M.D. <input type="checkbox"/> DIRECTOR		STAFF PHYS <input checked="" type="checkbox"/>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jerry J. Tomasovic, M. D.</b>			23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>9-10-66</b> 23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b> 23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>							
24. FUNERAL DIRECTOR <b>R. A. Pumphrey Funeral Home</b> 7557 Wisconsin Ave. Bethesda, Maryland					25a. REC'D BY REGISTRAR DATE <b>SEP 20 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Silver Spring	
d. LENGTH OF STAY IN lb 2 days		d. STREET ADDRESS 7723 Eastern Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mrs Marie Christine Satterfield		4. DATE OF DEATH Month Day Year 9 - 28 1966	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1906 5-23-xx 60 yrs.	
10a. J.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Des Moines, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bender		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James R. Satterfield (Same as # 2 above)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARBONIC ARREST 465X DUE TO (b) ANOXIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) MASSIVE PULMONARY EMBOLUS	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES, MELLITUS, CERUNARY ARTERY DISEASE	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-28, 1966, to 9-28, 1966 that (I) (we) last saw the deceased alive on 9-28, 1966, and that death occurred at 12:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE John L. Ford		22b. DATE SIGNED 9-28-66	
22c. PHYSICIAN'S NAME (Type) JOHN LOUIS FORD MD 831 UNIVER. BLVD E SILVER SPRING		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sep. 30, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR John B. Thomas, Warner E. Pumphrey, Inc.		25a. ADDRESS John B. Thomas, 8434 Georgia Ave., Silver Spring, Md.	
		25a. REC'D BY REGISTRAR OCT 3 1966	
		25b. REGISTRAR'S SIGNATURE Judge	



Cleared by Medical Examiner

**Dr. John Rogers**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

13031

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> D.O.A.			c. LENGTH OF STAY IN 16 <b>Hyattsville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium + Hosp</b> 6919 24th Ave			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <b>Earl Peter Scheuring</b>			4. DATE OF DEATH <b>9</b> Month <b>10</b> Day <b>1966</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>5-14-16</b>		9. AGE (In years at birthday) <b>50</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Reading, Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Christian Scheuring</b>			14. MOTHER'S MAIDEN NAME <b>Esther O'Toole</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>170 05 9287</b>		17. INFORMANT <b>Anne Scheuring</b> Address <b>6919 24th Ave Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY</b> <b>IMMEDIATE CAUSE (a)</b> <b>CARDIAC ARREST</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)</b> <b>DUE TO</b> <b>MYOCARDIAL INFARCTION</b> <b>DUE TO</b> <b>CORONARY ATHEROSCLEROSIS</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) <b>Hyattsville</b> (County) <b>Md.</b> (State) <b>20801</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7-5-1966</b> to <b>8-13-1966</b> that (I) (we) last saw the deceased alive on <b>8-13-1966</b> , and that death occurred at <b>7:50 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Oliver B. Bond</b>			22b. DATE SIGNED <b>LANHAM MD 20881</b>		
22c. PHYSICIAN'S NAME (Type) <b>OLIVER B. BOND</b>			22d. ADDRESS <b>6872 RIVERDALE ROAD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/15/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b> DATE <b>SEP 14 1966</b>		
25b. REGISTRAR'S SIGNATURE					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

CERTIFICATE OF DEATH

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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 5 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>		e. STREET ADDRESS <b>11604 LOCKWOOD DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN B. SCHNEIDER</b>		First <b>JOHN</b>	Middle <b>B.</b>
4. DATE OF DEATH <b>Sept 3 1966</b>		Last <b>SCHNEIDER</b>	Month Day Year Year
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>7-14-66</b>		9. AGE (In years last birthday) yrs. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>JOHN R SCHNEIDER</b>		14. MOTHER'S MAIDEN NAME <b>BONNIE BRODST</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>JOHN R. SCHNEIDER SAME AS (2d)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METABOLIC ACIDOSIS DUE</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>to UNDETERMINED CAUSE.</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>FT MYER, VA.</b>
20f. (City or town) <b>FT MYER</b>		(County) <b>VA.</b>	(State) <b>VA.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>7/25 1966</b> to <b>9/3 1966</b> , that (I) (we) last saw the deceased alive on <b>9/2 1966</b> , and that death occurred at <b>12:00 M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Herbert J. Jacobs MD</b>		22b. DATE SIGNED <b>Sept 3, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>HERBERT J. JACOBS</b>		22d. ADDRESS <b>HOLY CROSS HOSPT SILVER SPRING MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-7-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>ARLINGTON NATL FT MYER, VA.</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO</b>		25a. ADDRESS <b>8655 GA AVE.</b>	25b. REC'D BY REGISTRAR DATE <b>SEP 8 1966</b>
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



3:29

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13033

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY in lb <i>DOA</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>127 Hesketh St.</i>		d. STREET ADDRESS <i>127 Hesketh St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Schneider</i>	4 DATE OF DEATH Month 9 Day 11 Year 1966
S SEX <i>F</i>	6 COLOR OR RACE <i>Cau</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 NEVER MARRIED DIVORCED <input type="checkbox"/>
9. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Architect</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Architect</i>	
11b BIRTHPLACE (State or foreign country) <i>Austria</i>		12 CITIZEN OF WHAT COUNTRY? <i>Austria USA</i>	
13. FATHER'S NAME <i>Zubanik</i>		14. MOTHER'S MAIDEN NAME <i>Bozena Vana</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>Joseph J. Schneider</i>	
17. INFORMANT <i>Bozena Vana</i>		Address <i>Same as</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute intoxication from overdose of alcohol</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost.</i>		DUE TO (b) <i></i>	
DUE TO (c) <i>Chronic alcoholism</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) <i>Took too large a dose of alcohol</i>	
20c. TIME OF INJURY Month, Day, Year <i>5:00 p.m. 9/11 1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Montgomery Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John E. Bell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i></i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>13 Sept 66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR HILL Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Southland, P.G. Md.</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey, Bethesda, Maryland</i>		25a. RECEIVED BY REGISTRAR <i></i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>SEP 15 1966</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13034

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit.  Please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda-Chevy Chase</b>		c. LENGTH OF STAY IN lb <b>3 months</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5203 Murray Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>							
3. NAME OF DECEASED (Type or print) <b>Nora</b>		First <b>K.</b>	Middle <b>Schrider</b>	4. DATE OF DEATH <b>Sept 3, 1966</b>	Month <b>19</b>	Doy <b>1</b>	Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1894</b>	9. AGE (In years less birthday) <b>72 yrs</b>	11. IF UNDER 1 YEAR Months <b>0</b>	12. IF UNDER 24 HRS Days <b>0</b>	13. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. IND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Maurice J. Keane</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Whelan</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Marguerite K. Greene same as #1</b>		Address			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b>								INTERVAL BETWEEN ONSET AND DEATH	
b) <b>Primary Carcinoma of Stomach</b> Since <b>Jan. 16, 1965</b>									
c) <b>Metastasis to Liver &amp; Gall Bladder</b> 3 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 16, 1965</b> to <b>Sept. 3, 1966</b> that (I) (we) last saw the deceased alive on <b>Sept. 3, 1966</b> and that death occurred on <b>12/50</b> from causes and on the date stated above.									
22a. SIGNATURE <i>James Hawfield</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-9-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>James Hawfield M.D.</b>		22d. ADDRESS <b>1150 Conn. Ave. N. W. Wash. DC</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 7, 1966</b>		23c. NAME OF CEMETERY OR CREMORY <b>Mount Olivet</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>			
24. FUNERAL DIRECTOR <i>F. J. Collins</i>		ADDRESS <b>3821 - 14th St. NW WashDC</b>		25a. REC'D BY REGISTRAR <b>SEP 7 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

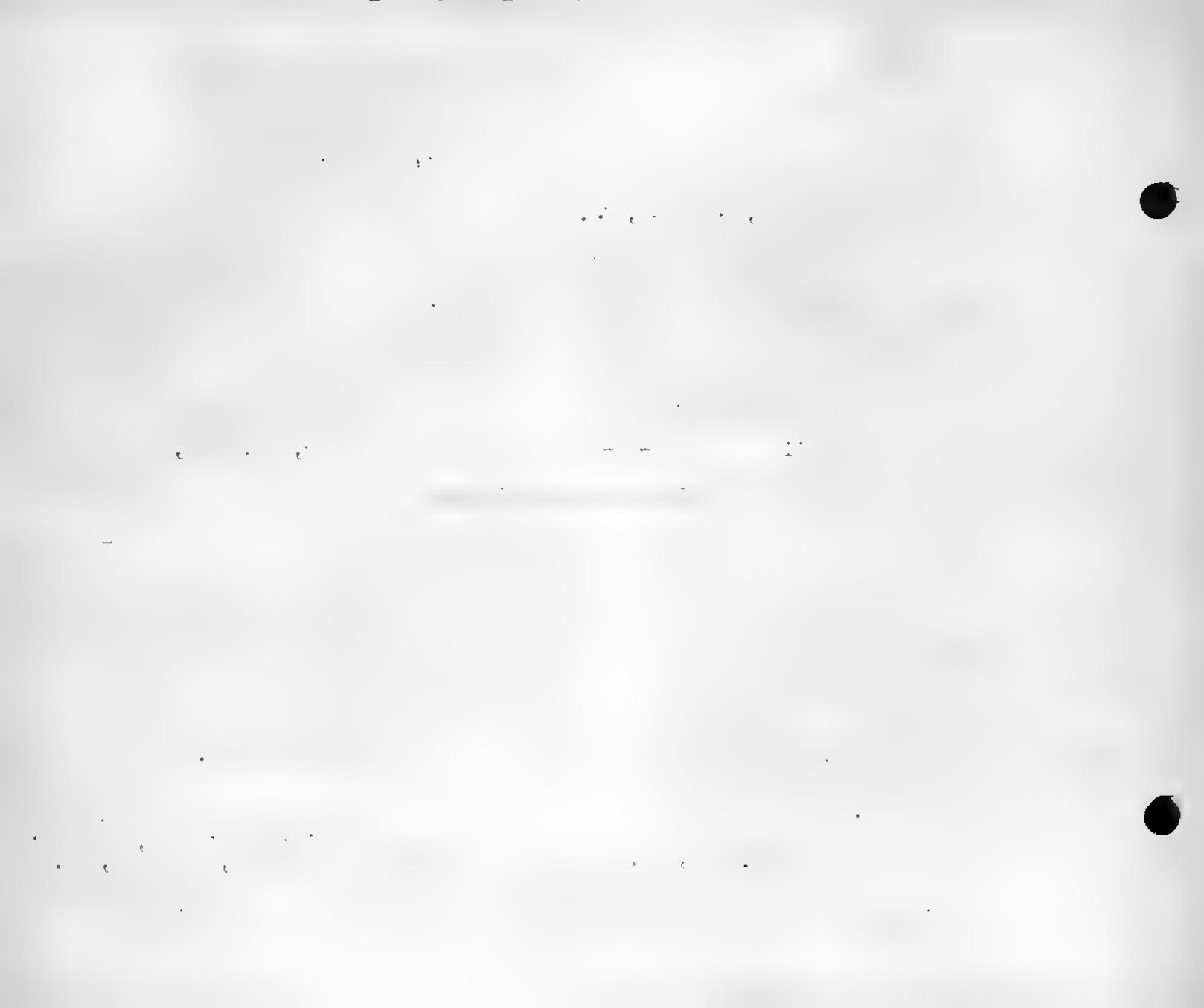
CERTIFICATE OF DEATH

13035

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Bethesda		115 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
The Clinical Center, Bethesda, Md.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9510 Seminole Street		Day Year	
3. NAME OF DECEASED (Type or print)		First	Middle
Eugene Joseph		Schubert	4. DATE OF DEATH Month Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Attorney		Law	
10c. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)	
Samuel Schubert		12. CITIZEN OF WHAT COUNTRY?	
13. MOTHER'S MAIDEN NAME		New York USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
Yes		130-07-1072	
17. INFORMANT		The Medical Record Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		The Clinical Center, Bethesda, Maryland	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] (b) Malignant Carcinoid Tumor	
(b) Small Bowel obstruction		INTERVAL BETWEEN ONSET AND DEATH 8 Years	
DUE TO (c) Uremia		3-4 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		1 Week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19			20f. (City or town) (County) (State)
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 25 May, 1966, to 17 Sept. 1966, that <input type="checkbox"/> (we) last saw the deceased alive on 17 Sept. 1966, and that death occurred at 5:55 PM, from the causes and on the date stated above.		22b. DATE SIGNED 1966	
22a. SIGNATURE Robert Zelis		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 17 September	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
Robert Zelis, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/66	23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat. Cemetery Arlington, Virginia
24. FUNERAL DIRECTOR		ADDRESS 3501-14th	25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Bernard Danzansky & Sons St. NW, Wash. D.C. DATE SEP 20 1966 Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13036

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. *Please remove carbon papers.* Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>0.04</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San + Hospital</i>		d. STREET ADDRESS <i>8609 Greenwood Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Marilyn M. McHale</i>		4. DATE OF DEATH <i>5-25-61</i>	Month <i>5</i> Day <i>14</i> Year <i>1961</i>
S SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-25-05</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
13. FATHER'S NAME <i>UNKNOWN</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Mr. Herbert J. Aikin, 714 University Street</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Str. Myocardial infarct</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aspirin</i>		years	
DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Diabetes Mellitus, U.v. Disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i> (County) <i></i> (State) <i></i>			
21. I certify that (I) (this hospital) attended the deceased from <i>July 1961</i> to <i>July 1961</i> , that (I) (we) last saw the deceased alive on <i>July 1961</i> , and that death occurred at <i>125 M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Marvin Schneider</i>		22b. DATE SIGNED <i>9/14/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Marvin Schneider</i>		22d. ADDRESS <i>911 S. 1st St., Spring Ave., Silver Spring, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Social</i>		23b. DATE THEREOF <i>9-18-66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>GEO. WASH. CEMETERY</i>		23d. LOCATION (City or Town) <i>Hyattsville</i> (County) <i>PG. MD</i> (State) <i></i>	
24. FUNERAL DIRECTOR <i>Goldberg Funeral Home 4217 Grant, N.W.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i> DATE <i>SEP 19 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

13033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>		c. LENGTH OF STAY IN 1b <i>13 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross</i>		e. STREET ADDRESS <i>14204 Bennington Pl</i>	
3. NAME OF DECEASED (Type or print) <i>DAPHNE E. SHABE</i>		4. DATE OF DEATH First      Middle      Last <i>14 14 1968</i>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
6. SEX <i>F</i>	7. COLOR OR RACE <i>CAU</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. DATE OF BIRTH <i>1914/68</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (County & State, or foreign country) <i>DC</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Mac Smi</i>	14. MOTHER'S MAIDEN NAME <i>MARY DECKER NAWL</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mac Smi</i>	Address <i>Time As 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral infarcts, right occipital (remote)</i>			
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>(b) and left parietal (recent) lobes</i>		DUE TO <i>(b) Acrotic stenosis (c) Downs syndrome</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8/29 1966</i> to <i>9/7/66</i> , 1966, that (I) (we) last saw the deceased alive on <i>9/6 1966</i> , and that death occurred at <i>4301 Aspen Hill Road</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Donald Straus</i>		22b. DATE SIGNED <i>9/6/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Donald Straus</i>		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>9-9-66</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Fr. Lincoln Cemetery</i>		23d. LOCATION (City, town or county) <i>WASHINGTON, D.C.</i>	
24. FUNERAL DIRECTOR <i>Goldberg Funeral Home</i>		25a. ADDRESS <i>4217-9th St. N.W.</i>	
25b. REC'D BY REGISTRAR <i>Charles Judge</i>		25c. DATE SEP 13 1966	

( ) ( ) ( ) ( )

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

1354

## CERTIFICATE OF DEATH

13038

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER DR REAP 7/

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>			c. LENGTH OF STAY IN 1b <b>5 hrs</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSPITAL</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>VICTORIA</b> First <b>EVA</b> Middle <b>SHERMAN</b>			4. DATE OF DEATH Month <b>9</b> Day <b>7</b> Year <b>1966</b>		
5. SEX <b>FE</b>		6. COLOR OR RACE <b>WT</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>6/7/19</b>		9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>stenographer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>State Dept</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Horner Sherman</b>			14. MOTHER'S MAIDEN NAME <b>EVA MARDRES</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>600-00-0000</b>		
17. INFORMANT <b>Hospital Records</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASHD &amp; Congestive heart failure 3 weeks</b>					
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Diabetes mellitus</b> DUE TO (c) <b>Unknown</b> DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>					
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Unknown</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Unknown</b>	
20f. (City or town) <b>Unknown</b>				(County) <b>Unknown</b>	
				(State) <b>Unknown</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1952</b> to <b>8/7</b> , 1966, that (I) (we) last saw the deceased alive on <b>8/7</b> 1966, and that death occurred at <b>8 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Herbert Wechsler</b>			22b. DATE SIGNED <b>8/8/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Herbert Wechsler MD</b>			22d. ADDRESS <b>1800 Eye St. N.W. Washington D.C.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-12-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>PROSPECT HILL</b>	
23d. LOCATION (City or Town) <b>Washington D.C.</b>				(County) <b>Washington</b>	
				(State) <b>D.C.</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>			ADDRESS <b>300 4th St. NE</b>		
25a. REC'D. BY REGISTRAR DATE <b>SEP 14 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13039

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. **Page 1 and 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Maryland b. COUNTY Prince Georges	
Bethesda		23 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
The Clinical Center, Bethesda, Maryland		7413 17th Avenue		e. DATE OF DEATH September 24 1966	
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Edward	Last Shields	Month	Day
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDERR 1 YEAR Months Days Hours Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2 July 1930	36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Photographer		News Service		12. CITIZEN OF WHAT COUNTRY? USA Washington, DC	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Vincent Shields		Kathryn Sheldon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address	
No		578-28-3618		The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale					
DUE TO (b) Pulmonary Fibrosis					
DUE TO (c) Hodgkins Disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 1, 1966 to Sept. 24, 1966, that <input type="checkbox"/> (we) last saw the deceased alive on Sept 24, 1966, and that death occurred at 1:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Martin H. Cohen					
22b. DATE SIGNED 24 Sept. 1966					
22c. PHYSICIAN'S NAME (Type)		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Sept 28-66		23c. NAME OF CEMETERY OR CREMATORIUM <i>Heets of Maryland</i>	
24. FUNERAL DIRECTOR		ADDRESS <i>Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>Arthur Walters</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur Walters</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #300919/6 pg

## CERTIFICATE OF DEATH

13040

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death  
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 9 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		e. STREET ADDRESS RT. 3		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHARLIE		First MIDDLE BRITTON		Last SHRADER		4. DATE OF DEATH SEPTEMBER 14, 1966	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 12/17/07		9. AGE (In years at birthday) 58 9 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State or foreign country) VIRGINIA			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOSEPH SHRADER			14. MOTHER'S MAIDEN NAME NELLIE ASBURY						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 229-18-1578			17. INFORMANT HOSPITAL RECORDS,			Address OLNEY, MARYLAND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <span style="float: right;">interval between onset and death</span> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> (b) <u>Coronary Artery Disease with myocardial</u> DUE TO (c) <u>infarction 8 days ago.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema.									
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/13/66</u> , 19 <u>66</u> , to <u>9/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/14/66</u> , 19 <u>66</u> , and that death occurred at <u>4:00 P.M.</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>Richard A. Yates, M.D.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/14/66</u>	
22c. PHYSICIAN'S NAME (Type) RICHARD A.		22d. ADDRESS OLD BALTIMORE RD., OLNEY, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-17-66		23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Memorial Gardens.		23d. LOCATION (City or Town) (County) (State) Frederick, Md.			
24. FUNERAL DIRECTOR <u>Ernest C. Garther</u>		ADDRESS Ernest C. Garther. Gaithersburg. Md.		25a. REC'D BY REGISTRAR DATE SEP 16 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

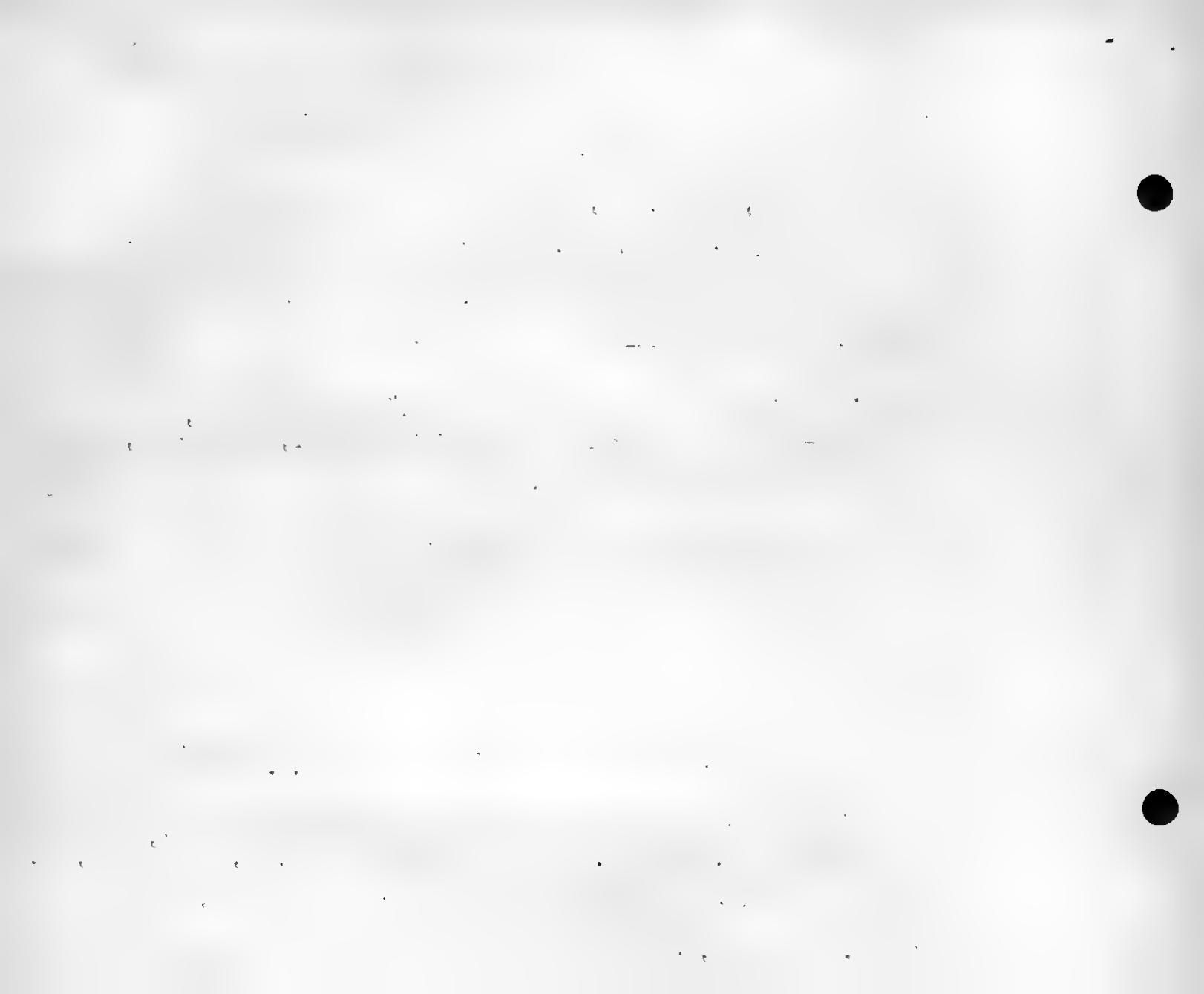
## CERTIFICATE OF DEATH

13041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>37 Days</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>New Jersey</b>		b. COUNTY <b>Essex</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex Fells</b>		f. STREET ADDRESS <b>295 Roseland Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Allen</b>	Middle <b>Castelnau</b>	Last <b>Siebens</b>	4. DATE OF DEATH Month <b>September</b>	Day <b>24</b>	Year <b>1966</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5 December 1918	9. AGE (In years last birthday) <b>47 yrs.</b>	10. IF UNDER 1 YEAR Months <b>9</b>	11. IF UNDER 24 HRS. Days <b>19</b>	12. IF UNDER 24 HRS. Hours Min. <b>1 Minute</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Director</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Arthur T. Siebens</b>		14. MOTHER'S MAIDEN NAME <b>Irene Westphal</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1942-46</b>		17. INFORMANT The Medical Records, Not Available		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Arrest</b> DUE TO (b) <b>Metastatic Hypernephroma</b> 7 Years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 Minute</b>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>18 August 1966</b> to <b>24 September 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>24 September 1966</b> , and that death occurred at <b>3:04 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE 		22b. DATE SIGNED <b>1966</b>						
22c. PHYSICIAN'S NAME (Type) <b>Herbert E. Kann, MD.</b>		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 24 September						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>9-26-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) <b>Suitland, Maryland</b>				
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. ADDRESS <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25b. REC'D BY REGISTRAR <b>SEP 27 1966</b>		25c. REGISTRAR'S SIGNATURE 				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

868  
CERTIFICATE OF DEATH

13042

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE		b. COUNTY			
Montgomery, MARYLAND		BETHESDA				Md.		Montgomery					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		CONGRESSIONAL MANOR NURSING HOME											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM?				
HELENA P.				SMITH	SEPT	16	1966	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County, & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
Female		White	Dec. 15, 1915	50 yrs.	At Home	Calif.	U.S.						
13. FATHER'S NAME		Charles W. Parnellce		14. MOTHER'S MAIDEN NAME		Ivy J. Steele		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH					
No		yes-UNKNOWN		Alvan M. Smith		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Paralysis		1 hr.					
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) Non-Malignant Brain Tumor		DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		11+4 yrs.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 15, 1966, to Sept 16, 1966, that (I) (we) last saw the deceased alive on Sept 15 1966, and that death occurred at 11:50 AM, from the causes and on the date stated above.		22a. SIGNATURE W.H. Clements		22b. DATE SIGNED Sept 16, 1966		22c. PHYSICIAN'S NAME (Type) William H. Clements		22d. ADDRESS 6001-35th Ave, Hyattsville, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL 9/20/66 Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR W.W. Chambers G. ADDRESS 8655- Ga. Ave, Sil. Spring		25a. REC'D BY REGISTRAR DATE SEP 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge									



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3749

## CERTIFICATE OF DEATH

13043

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN lb 29 hours		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital			e. STREET ADDRESS 3408 Greenastle Road		
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Walter	Middle Harper	Last Smith	4. DATE OF DEATH September 28 1966	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-70	9. AGE (in years lost birthday) 96 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ac't Union Pacific RR - RAILROAD			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Reed Smith			14. MOTHER'S MAIDEN NAME Rosetta Puder		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Spanish American War Unknown			16. SOCIAL SECURITY NO. Address Records - Washington San & Hospital		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Advanced Arteriosclerosis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myelogenous Leukemia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
21. I certify that (I) (this hospital) attended the deceased from 1964, 19, to 9/28, 1966, that (I) (we) last saw the deceased alive on 9/28, 1966, and that death occurred at 10:57 P.M., from causes and on the date stated above.			20e. (City or town) (County) (State)		
22a. SIGNATURE Joseph E. Smith, Jr.			22b. DATE SIGNED 9/29/66		
22c. PHYSICIAN'S NAME (Type) Joseph E. Smith, Jr.			22d. ADDRESS Burtonsville, Md.		
23a. BURIAL, CREMATION, BENOVIA (Specify) Burial		23b. DATE THEREOF 10/3/1966		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hebron Cemetery	
24. FUNERAL DIRECTOR C. C. CHAMBERS, Inc.		ADDRESS 5100 Spring Hill		25a. REC'D BY REGISTRAR OCT 3 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

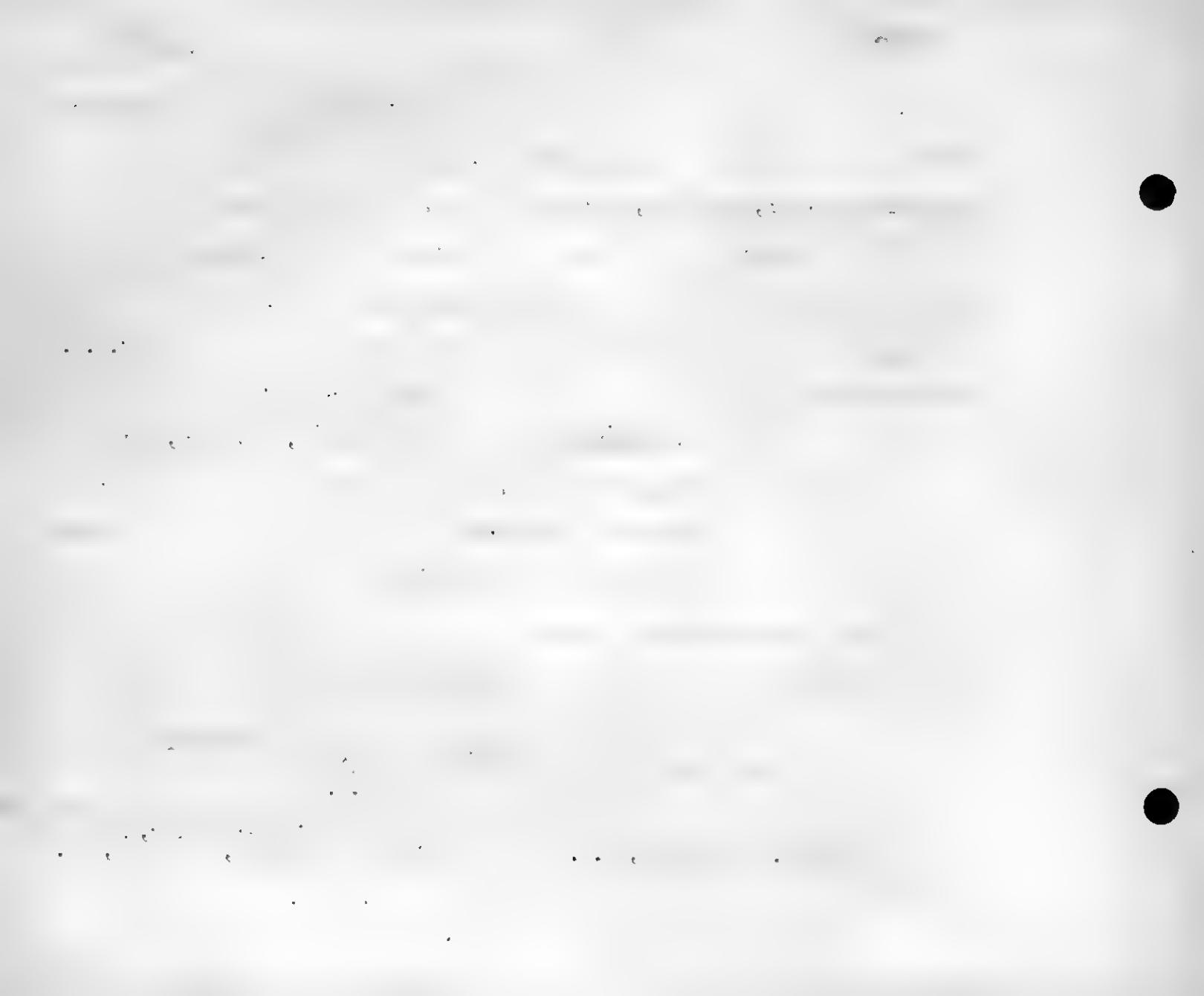
## CERTIFICATE OF DEATH

13044

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. <sup>Please remove carbon paper. Pages 1 and 2</sup> and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or cremoval, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>157 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>		d. STREET ADDRESS <b>11714 Castlewood Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Maury</b>		First <b>(None)</b>		Middle <b>Soltes</b>		Last <b>September</b>		4. DATE OF DEATH Month <b>6</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 December 1930</b>		9. AGE (In years last birthday) 95 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surgeon</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Soltes</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Rachefsky</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>763-527-298</b>		17. INFORMANT Address <b>The Medical Records The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <b>Pulmonary sepsis unknown etiology</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <b>Salmonella Septicemia</b>		2 weeks					
DUE TO <b>Acute myelogenous leukemia</b>		(c)		2 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Unknown heart disease 3 weeks</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED Month, Day, Year Hour a.m. p.m. <b>19</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) (County) (State)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED Month, Day, Year Hour a.m. p.m. <b>19</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) (County) (State)			
21. I certify that <b>Joel J. Rubenstein</b> attended the deceased from <b>2 April 1966</b> to <b>6 September 1966</b> , that <b>we</b> last saw the deceased alive on <b>September 6 1966</b> , and that death occurred at <b>1:17 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Joel J. Rubenstein</b>		P.M. M.D. ATTENDING PHYS. <input type="checkbox"/> M.E. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6 September 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Joel J. Rubenstein, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-8-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Shearith Israel Cong.</b>		23d. LOCATION (City, town or county) (State) <b>Cem. Dallas, Texas</b>			
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>		ADDRESS <b>3501 14th St. Washington DC</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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13051

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## CERTIFICATE OF DEATH

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (rural)	c. LENGTH OF STAY IN lb 54 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital		d. STREET ADDRESS 10307 GARDINER AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Female	First Dorothy Cuthbert SOWARD	Middle	Last September 18 1966
4. DATE OF DEATH Month Year	Month Year	Day Month	Day Year
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 16, 1901
9. AGE (In years lost birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 2	12. HOURS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
13. FATHER'S NAME Edward MINNIS		14. MOTHER'S MAIDEN NAME Lillian BANNISTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578 07 2373	
17. INFORMANT Morris S. SOWARD 10307 Gardiner Ave,		Address Silver Spring MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Pancreas		INTERVAL BETWEEN ONSET AND DEATH	
15 IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 25, 1966, to Sept. 18, 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 18 September 1966, and that death occurred at 129A M, from causes and on the date stated above.			
22a. SIGNATURE F. D. KEENAN		22b. DATE SIGNED 18 SEPT 66	
22c. PHYSICIAN'S NAME (Type) F. D. KEENAN		22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/1966	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National
24. FUNERAL DIRECTOR R.A. PUMPHREY 7557 Wisconsin Ave, Bethesda, MD.		ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 20 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13046

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
a. COUNTY <b>Montgomery</b>		a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		b. COUNTY <b>Mont.</b>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>100 W. Montgomery Avenue</b>		d. STREET ADDRESS <b>100 W. Montgomery Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Nora</b>		First <b>Nora</b>	Middle <b>M.</b>
4. DATE OF DEATH <b>7/1/1966</b>		5. DATE OF BIRTH <b>7/1/1914</b>	6. AGE IN YEARS <b>52</b>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. IF UNDER 1 YEAR <b>2</b> Months Days <b>23</b> Hours Min	
9. IF UNDER 24 HRS <b>23</b> Hours		10. BIRTHPLACE (State or foreign country) <b>Redwood, Virginia</b>	
11. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		12. MOTHER'S MAIDEN NAME <b>Lillie (Unknown)</b>	
13. FATHER'S NAME <b>William Crook</b>		14. INFORMANT Husband <b>Maynard Spangler</b> Same as Item 2.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause  DUE TO (b) _____ DUE TO (c) _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  Congestive Heart Failure -  Pulmonary Emphysema -  Fibro Calcification Pulmonary Diffuse. Years  INTERVAL BETWEEN DEATH AND DEATH <b>1m.</b>  Years	
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>7/25/66</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-27-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Calloway Cemetery</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		23d. LOCATION (City or Town) (County) (State) <b>Calloway, Virginia</b>	
25a. ADDRESS <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25b. REC'D BY REGISTRAR <b>SEP 1 1966</b>	25c. REGISTRAR'S SIGNATURE <i>James Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

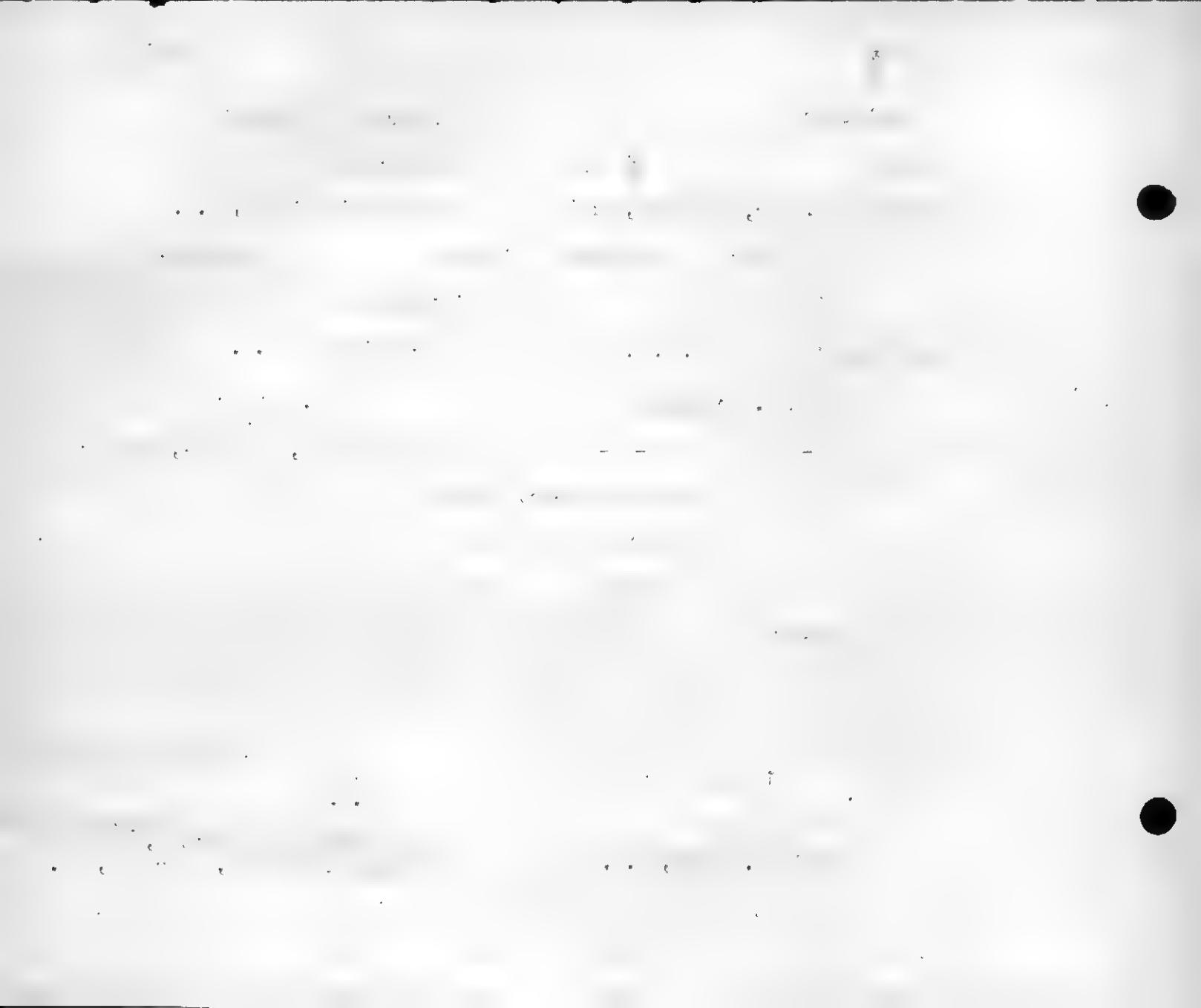
13047

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		Item 1c Film G-81 10/18/66		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>36 days</b>		a. STATE <b>District of Columbia</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		e. STREET ADDRESS <b>5330 Sherrier Place, N.W.</b>		b. COUNTY <b>Washington</b>	
3. NAME OF DECEASED (Type or print) <b>Edward Dalridge Spedden</b>		4. DATE OF DEATH Month <b>September 1 1966</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 January 1898</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Administrative</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C. &amp; P. Telephone Co.</b>		9. AGE (in years, last birthday) <b>68 yrs.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William D. Spedden</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Beavers</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1914-1918 577-01-0462</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>					
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Systemic Amyloidosis</b>		10 months			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Polycythemia</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERRULYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>(County)</b> <b>(State)</b>					
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>7 July 1966</b> to <b>1 September 1966</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>1 September 1966</b> , and that death occurred at <b>3:10 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Lewis R. Chase, M.D.</b>			
		22b. DATE SIGNED <b>1 September 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lewis R. Chase, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 6, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cem.</b>	
23d. LOCATION (City, town or county) <b>Arlington, Virginia</b>		(State)			
24. FUNERAL DIRECTOR <b>H. Rev. Revol</b>		ADDRESS D.C. <b>2222 Wis.Ave.N.W.Wash.</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or burial, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13048

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE					
Montgomery MARYLAND		MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY					
Silver Spring 23 Days		Mont.					
c. LENGTH OF STAY IN TD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS					
Holy Cross Hospital		3121 Jennings Rd.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle				
MARYDALE Speitler							
4. DATE OF DEATH		Month	Day Year				
5. SEX		5. COLOR OR RACE	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
7. DATE OF BIRTH		8. AGE (In years last birthday)	9. IF UNDER 1 YEAR Months Days Hours Min.				
8-21-33		33 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY					
Private Secretary		Publishing Co.					
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY					
Maryland		USA.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Robert Morris		Elizabeth Corkhill					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFIRMITY					
No		577-42-4505 Unknown					
Dolan R. Speitler, Same as #2 above.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Sepsis (clinical)				
		DUE TO (c)	Sub-Phrenic Abscess & Wound infections & Regional Enteritis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 8-30, 1966, to DEATH, 19, that (I) (we) last saw the deceased alive on 9-21, 1966, and that death occurred at 12:30 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 9/22/66					
22a. SIGNATURE Dr. Ira Miller		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.				
22c. PHYSICIAN'S NAME (Type) Dr. Ira Miller		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation Sept 24, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Foothills Crematory		23d. LOCATION (City, town or county) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR W.W. Chambers Inc. Silver Spring, Md.		ADDRESS		25a. REC'D BY REGISTRAR SEP 23 1966		25b. REGISTRAR'S SIGNATURE Ira J. Miller	

10 N

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13049

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORONER NOTIFIED AND APPROVED

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>410</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium</b>		d. STREET ADDRESS <b>1400 Roxanna Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Solomon</b>	Middle mnm	Last <b>Spigel</b>
4. DATE OF DEATH	Month <b>September</b>	Day <b>23<sup>rd</sup></b>	Year <b>1966</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/1881</b>
9. AGE (In years at birthday) <b>85</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. AGE (In years at birthday) Yrs <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Radom, Poland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mr. Benjamin Spigel</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
4x01		<i>Myocardial infarction</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		<i>Anterior sclerosis of heart disease</i>	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1966</b> to <b>Sept 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 1, 1966</b> , and that death occurred at <b>4 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>W. Shafrazi, M.D.</i>		22b. DATE SIGNED <b>Sept 24, 1966</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/25/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Adas Israel Cemetery</b>
23d. LOCATION (City or Town) <b>Washington, D.C.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons St. NW, Wash. DC</b>		25a. ADDRESS <b>3501-14th</b>	25b. REGISTRAR'S SIGNATURE <b>Stephens, 13049</b>
		25c. REC'D BY REGISTRAR <b>Stephens</b>	25d. DATE <b>Sept 24, 1966</b>



FOR STATE  
HEALTH DEPTItems 18 & 20 Film 382  
10-24-66MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3056

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13050

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Please page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission on) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. LENGTH OF STAY IN 1b <i>D.O.A.</i>		d. STREET ADDRESS <i>7311 Piney Br Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San. &amp; Hosp.</i>		e. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First <i>Cecil</i>	Middle <i>Glenn</i>	Last <i>Stamps</i>
4 DATE OF DEATH <i>Sept 12 1966</i>	Month Year	Day	Year
5 SEX <i>M</i>	6 COLOR OR RACE <i>Cauc.</i>	7 MARRIED WIDOWED <input type="checkbox"/>	8 NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
10a. OCCUPATION (Give kind of work done during most of work life even if retired) <i>Cab Driver</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Cab</i>	11 BIRTHPLACE (State or foreign country) <i>Sunbury, Penna.</i>	
13. FATHER'S NAME <i>William Stamps</i>	14. MOTHER'S MAIDEN NAME <i>Anna Walshaw</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO <i>57722572</i>	17. INFORMANT <i>Police Dept., Tak. Pk., Md.</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiorespiratory failure due to</i>			
DUE TO (b) <i>Barbiturate intoxication, self-administered</i>			
DUE TO (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>None</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b) <i>Deceased took overdose of barbiturate (apparently Seconal)</i>	
20c. TIME OF INJURY Month, Day, Year Hour or m. <i>2:00 AM 9-10 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <i>Home</i>
20f. (City or town) <i>Takoma Park</i>		(County) <i>Montg.</i>	
(State) <i>Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John R. Stamps</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John R. Stamps</i>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John R. Stamps</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) <i>1919 Seminary Rd. S.E. Montg.</i>			
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/14/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat. Cem.</i>
23d. LOCATION (City or Town) <i>Arlington, Va.</i>		(County) <i>Montgomery</i>	
(State) <i>Va.</i>			
24. FUNERAL DIRECTOR Home Inc.		25. ADDRESS <i>Mt. Rainier, Maryland</i>	
26. REC'D BY REGISTRAR		26b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>SEP 15 1966</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

13057

## CERTIFICATE OF DEATH

13051

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or embalming, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Life		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9000 Stewart Avenue		d. STREET ADDRESS 9000 Stewart Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Albert	Middle Stewart	4. DATE OF DEATH Sept. 1, 1966
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 4, 1883		9. AGE (In years last birthday) 83 yrs	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Steward		14. MOTHER'S MAIDEN NAME Louise Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service		16. SOCIAL SECURITY NO	
17. INFORMANT Emma Steward		Address same as item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) DUE TO (d)			
Carcinoma Prostate Generalized Carcinomatosis 2 years			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-11, 1966 to 91, 1966 that (I) (we) last saw the deceased alive on 8/21, 1966, and that death occurred at 2 PM, from causes and on the date stated above.			
22a. SIGNATURE Calvin B. LeCompte		22b. DATE SIGNED 9/1/66	
22c. PHYSICIAN'S NAME (Type) Calvin B. LeCompte		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 61 R. St. N.E.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/4/66	23c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial
23d. LOCATION (City or Town) Sandy Spring, Md.			
24. FUNERAL DIRECTOR Robert L. Snowden		25a. REC'D BY REGISTRAR DATE SEP 3 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
ADDRESS Rockville, Md.			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13052

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-train Permit. **Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.**

3258		2	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN lb <i>1 1/2 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. Hospital.</i>		d. STREET ADDRESS <i>8308 Flower Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Margaret Cover Strunk</i>		4. DATE OF DEATH Month Day Year <i>Sept. 5 1966</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-8-91</i>	
9. AGE (In years last birthday) <i>75 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> <i>America</i>	
13. FATHER'S NAME <i>Thomas Davis</i>		14. MOTHER'S MAIDEN NAME <i>Franklin Russell Magdaline</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>578-50-2834</i>	
17. INFORMANT <i>Mrs. Virginia Nelson</i>		18. ADDRESS <i>med records - W.S.H. Bldg. Md.</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. INTERVAL BETWEEN ONSET AND DEATH <i>10-15-2-1966 - 11-5-66</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m.		20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>3 Sept. 1966</i> , that (I) (we) last saw the deceased alive on <i>13-1-66</i> , and that death occurred at <i>4 DC &amp; M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Edward C. Wilson, Jr.</i>		22b. DATE SIGNED <i>5-3-1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Wilson, Jr.</i>		22d. ADDRESS <i>1801 Eye St., N. W.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sep. 7, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Md.</i>	
24. FUNERAL DIRECTOR <i>Clark C. Wilson Warner E. Pumphrey, Inc.</i>		25a. ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>	
25b. RECEIVED BY REGISTRAR <i>Charles Judge</i>		25c. DATE <i>SEP 9 1966</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the completed form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13053

1. PLACE OF DEATH  
COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1B

209 @ 245 fm

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Washington

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

La Conner

4:3

d. STREET ADDRESS

P.O. Box 464

e. IS RESIDENCE  
ON A FARM?

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

male

6. COLOR OR RACE  
white

7. MARRIED  
WIDOWED

NEVER MARRIED  
DIVORCED

8. DATE OF BIRTH  
7-11-46

9. AGE (in years  
last birthday)  
20 yrs.

10. IF UNDER 1 YEAR  
Months

11. IF UNDER 24 HRS.  
Days

Hours  
Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Soldier

10b. KIND OF BUSINESS OR  
INDUSTRY

U.S. ARMY

11. BIRTHPLACE (State or foreign country)

Washington

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

13. FATHER'S NAME

Ernest A. Sut

14. MOTHER'S MAIDEN NAME

Betty Wark

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

Yes Active Duty

16. SOCIAL SECURITY NO.

533 44 963

INFORMANT

Ernest A. Sut

Address

Same as #2

17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Rupture inferior vena cava with exsanguination

INTERVAL BETWEEN  
ONSET AND DEATH

5224

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) due to automobile accident.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 2 pm. 9/8 1966

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Was riding in car on 7020 - last contract - turned over

Highway 705 Gaithersburg Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion

death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22. DATE SIGNED

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

9/12/66

23c. NAME OF CEMETERY OR CREMATORIAL

Mt. Vernon

23d. LOCATION (City, town or county) (State)

Mt. Vernon, Wash.

24. FUNERAL DIRECTOR

W.W. Chambers Co Inc

ADDRESS

1400 Chapin St. NW  
Washington, D.C.

25a. REC'D BY REGISTRAR

DATE SEP 13 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

**13054**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Selmer Spring</b>	c. LENGTH OF STAY IN 1b <b>7mo - 17 days</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FAIRLAND NRSG HOME 2101 FAIRLAND RD.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>GRACE</b>	First <b>GRACE</b>	Middle <b>HAMILTON</b>	Last <b>SULLIVAN</b>	4. DATE OF DEATH <b>SEPT 12 1966</b>	Month Day Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 28, 1896</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BEAUTICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>SAMUEL F. FOWLER</b>		14. MOTHER'S MAIDEN NAME <b>DAVIS, Alice E</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Edward J. Sullivan</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO (b) <b>coronary arteriosclerosis</b> DUE TO (c) <b>generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Cerebral arteriosclerosis, Senile psychosis</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1966</b> to <b>9/12 1966</b> , that (I) (we) last saw the deceased alive on <b>9/12 1966</b> , and that death occurred at <b>1240 M</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Raymond T. Benack</b>		22b. DATE SIGNED <b>9/12/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Raymond T. Benack MD</b>		22d. ADDRESS <b>4115 Colic Dr., Wheaton, md.</b>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <b>Burial Sept 15-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Linthorpe, Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Hammes Bros - 1661 - Good Hope Rd SE</b>		25a. READ BY REGISTRAR DATE <b>SEP 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13055  
CERTIFICATE OF DEATH

13055

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS</b>		d. STREET ADDRESS <b>12613 Millstream Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Charlotte First Baby Girl</b>		FAYE Middle		Last		4. DATE OF DEATH <b>TALBERT</b>		Month Year 9 28 1966		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH <b>9-26-66</b>		9. AGE (In years last birthday) yrs. <b>Montgomery County, Md.</b>		10. IF UNDER 1 YEAR Months <b>1</b>	11. IF UNDER 24 HRS Days <b>2</b>	12. Hours <b>53</b>
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Wilber D. Talbert</b>		14. MOTHER'S MAIDEN NAME <b>Audrey S. Branch</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>11/A</b>		17. INFORMANT <b>Wilbur D. Talbert Dr., Bowie, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1945</b>		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), listing the underlying cause <b>Atelectasis</b>		DUE TO (c) ? Cong heart disease				INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>9/27 1966</b> to <b>9/28 1966</b> , that (I) (we) last saw the deceased alive on <b>9/28 1966</b> , and that death occurred at <b>2:50AM</b> , from causes and on the date stated above.										
22a. PHYSICIAN'S NAME (Type) <b>M. J. Mones</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-28-66</b>		
22c. ADDRESS <b>110 Spring St SS Md</b>										
23a. BURIAL, CREMATION, TRANSIT <b>BURIAL</b>		23b. DATE THEREOF <b>Sept. 30, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery, Arlington, Virginia</b>		23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR <b>Sharon A. Wadley, Lavel, Md</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Sharon A. Wadley</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13056

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Reused with Medical Examiner (Dr. Real)

1. PLACE OF DEATH a. COUNTY	Items #2c, 8 & 9 Film #10301			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
Montgomery	MARYLAND			a. STATE b. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Bethesda	2 yr. 7 mo.			Westgate
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Congregational Manor Sanitarium			d. STREET ADDRESS 4444 1/2 Rock Road NW
3. NAME OF DECEASED (Type or print)	First	Middle	Last	6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Female	CLIFFORD	ESTELLE	TALBOT	Month Day Year 9 30 1966
5. SEX	6. COLOR OR HAIR	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 83	9. AGE (in years) last b'day
Female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11-26-84	12. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS Months Days Hours Min. 82 8 4 4 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or fore in country)		
Housewife	AT HOME	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			Address West.
Emory F. Malone	SARAH Isabelle Campbell			5107 Fairlington Dr., 1602
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH	
No	577-68-6273	mae B.E. Landon	20 yrs.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident				
77.1X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.				
DUE TO (b) Cerebral Arterio Sclerosis				
DUE TO (c) Hypertension and Cerebrovascular Disease				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19				
21. I certify that (I) (X) this hospital attended the deceased from March, 1965, to 9-30, 1966, that (I) (we) last saw the deceased alive on 9/28 1966, and that death occurred at 1 P.M., from the causes and on the date stated above.				
22a. SIGNATURE Louis Gillespie, Jr.				
22b. DATE SIGNED 9-30-66				
22c. PHYSICIAN'S NAME (Type) Louis Gillespie, Jr.				
22d. ADDRESS 1714 N ST. N.W., WASH. D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-3-66	23c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEM.	23d. LOCATION (City, town or county) SUITLAND MD. (State)
24. FUNERAL DIRECTOR Jos. GAWLER'S SONS -		5130 1/2 S. AVE. N.W.	25a. REC'D BY REGISTRAR OCT 5 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13057	
I. PLACE OF DEATH					2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Montgomery MARYLAND					a. STATE D. C.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 1 Day					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Silver Spring					d. STREET ADDRESS 3045 Vista Street, N.E.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First William	Middle	4. DATE OF DEATH THOMAS	Month September	Day 8	Year 1966				
5. SEX Male		6. COLOR OR RACE Col.	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-22-06	9. AGE (In years last birthday) 60 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS Hours	13. MIN Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)			16. SOCIAL SECURITY NO			17. INFORMANT			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Burns, second &amp; third degree, 90% of body area</i>										INTERVAL BETWEEN ONSET AND DEATH 25 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Painter. Gasoline vapors ignited by hot water heater and flash fire burned him.										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTR. BLITING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Painter. Gasoline vapors ignited by hot water heater and flash fire burned him.									
20c. TIME OF DEATH Month Day Year Hour am 10:00 a.m. 19 XXX9-7-66 19		20d. INJURY LOCATED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			20e. (City or town) (County) (State) Silver Spring Mont. Md.						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John S. Rogers</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) John S. Rogers, M.D.		22. DATE SIGNED 9-8-66									
23a. BURIAL/CREMATION/REMOVAL (Specify) 1919 Seminary Road, Silver Spring, Md.		23b. DATE THEREOF 9-12-66			23c. NAME OF CEMETERY OR Crematory Penley			23d. LOCATION (City or town) (County) (State) La Plata 3rd -			
24. FUNERAL DIRECTOR <i>Johnson Jackson 4801 1/2 Ave. N.W.</i>		ADDRESS			25a. REC'D BY REGISTRAR Date SEP 13 1966			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15ME (5) 6M 1/66											



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

## CERTIFICATE OF DEATH

13058

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chevy Chase Nursing & Convalescent Center		d. STREET ADDRESS 1810 Irving St. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Marietta	Middle S	Last Tucker	4 DATE OF DEATH September 26 1966	Month Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH Sept. 2 1904	9. AGE (In years last birthday) 62 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Research Assistant-Bureau of Labor Statistics-Babor Dept.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Harford County, Maryland	
13. FATHER'S NAME Lewis F. Scarborough		14. MOTHER'S MAIDEN NAME Mary Elizabeth Bailey		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Henry A. Tucker, Jr. 1810 Irving St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> INTERVAL BETWEEN ONSET AND DEATH 3 months.					
15 IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 25, 1966</u> to <u>Sept 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 22, 1966</u> , and that death occurred at <u>1726 Eastern Wash.</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Harry Friedenberg</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/26/66		
22c. PHYSICIAN'S NAME (Type) <u>HARRY FRIEDENBERG</u>		22d. ADDRESS 1726 Eastern Wash.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/1/66	23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery	23d. LOCATION (City or Town) Georgetown, Del.	(County) (State)
24. FUNERAL DIRECTOR <u>The S. H. Nines Co.</u>		25a. ADDRESS 2901 14th St. N.W. Washington D.C.	25b. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles J. Charles J. Judge	
VR A15 (4) 20 M. 1/66		DATE SEP 28 1966			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

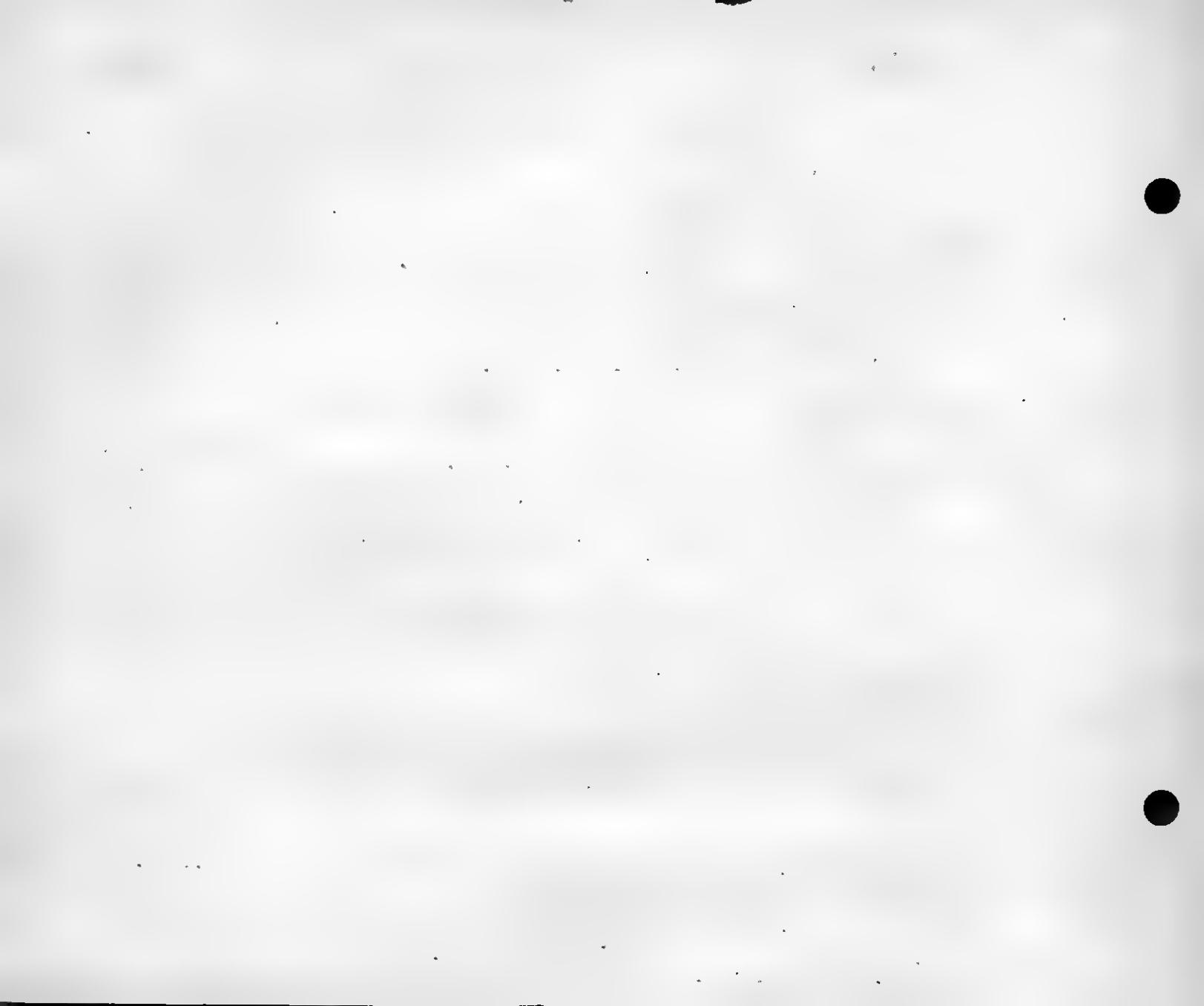
13059

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San. &amp; Hospt.</i>		e. STREET ADDRESS <i>Silver Spring</i> <i>2016 Luzerne Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>JOSEPH</i>		First <i>Stanley</i>	Middle <i>xxxxxx</i>
		Last <i>Jurowski</i>	4. DATE OF DEATH <i>Sep. 21 1966</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>7-4-1900</i>		9. AGE (In years last birthday) <i>66 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Eng. plant operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Was. Sub. San. Com. Polard</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Stanley Jurowski</i>		14. MOTHER'S MAIDEN NAME <i>Alexandria Milewski</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO <i>215-38-3118</i>	
17. INFORMANT <i>Pearl R. Jurowski</i>		Address <i>2016 Luzerne Ave. Silver Spring, Md.</i>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4220</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Chv. myocardial</i> DUE TO (c) <i>Acute myocardial</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Diabetes</i>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1966</i> to <i>Aug. 21, 1966</i> ; that (I) (we) last saw the deceased alive on <i>Sept. 16, 1966</i> , and that death occurred at <i>81 M</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>9-21-66</i>	
22a. SIGNATURE <i>John S. Rogers, M.D.</i>		ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>John S. Rogers</i>		22d. ADDRESS <i>1919 Seminary Rd., S. S., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sep. 23, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas, John B. Thomas, Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR <i>SEP 26 1966</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12066 CERTIFICATE OF DEATH 13060

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 13808 Old Columbia Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakton	
d. STREET ADDRESS 3001 Cyrandal Valley Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Catherine	4. DATE OF DEATH Month Sept. 5, 1966 Year
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 15, 1885		9. AGE (In years last birthday) 81 yrs	
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Loudoun Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John T. Milstead		14. MOTHER'S MAIDEN NAME Mary Jane Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Raymond T. Underwood, Oakton, Virginia		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Congestive heart failure (c) DUE TO arteriosclerotic heart disease, known type		INTERVAL BETWEEN ONSET AND DEATH 3-10-12 hrs known type	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Old C. V. Asthma, hemoptysis, ② Marked emaciation		3. Did autopsy WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 11-4-65, 19 to 9-5, 1966, that (1) (we) last saw the deceased alive on 9-4, 1966, and that death occurred at 1200 M. from causes and on the date stated above.		22b. DATE SIGNED 9-5-66	
22a. SIGNATURE John R. Spencer		22b. ADDRESS BURTONSVILLE, MARYLAND Co.	
22c. PHYSICIAN'S NAME (Type) John R. Spencer		22d. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 7, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Chestnut Grove		23d. LOCATION (City or Town) (County) (State) Herndon, Fairfax Co., Va.	
24. FUNERAL DIRECTOR Charles Judge		25a. ADDRESS 13066	
		25b. REGD. BY REGISTRAR DATE SEP. 7 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 13075

executed within 24 hours after death.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**3. FUNERAL DIRECTOR:** After this certificate has been signed by the director, page 3 should be detached for use as the burial fraction. It should be filed with the State Dept. of Health.

Medical Certification  
Examiner: Robert E. Selden Reg. No. 123456789  
Accepted  
for signature  
on 10/10/2010

PLACE OF DEATH C. COUNTY	
D. CITY OR TOWNSHIP write RURAL <i>Takoma</i>	
d. NAME OF HOSPITAL <i>Washington</i>	
NAME OF DECEASED (Type or print) <i>Female</i>	
SEX <i>Housewife</i>	
E. USUAL OCCUPATION During most of work <i>Housewife</i>	
3. FATHER'S NAME <i>Franklin</i>	
5. WAS DECEASED (Yes, no, or unknown) <i>No</i>	
18. CAUSE OF DEATH PART I. DEATH <i>Conditions, If gave rise to cause (a), underlying cause</i>	
PART II. OTHER <i>Frac</i>	
20a. ACCIDENT OR CONTRIBUTING (If either, not both) <i>Hour a.m.</i>	
20b. TIME OF DEATH <i>85</i> Hour a.m. p.m.	
21. I certify saw the deceased 22a. SIGNATURE <i>[Signature]</i>	
22c. PRACTICIAN NAME (Type) <i>[Signature]</i>	
3a. BURIAL, CREMATION REMOVAL (Specify)	

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(If yes give war or date  
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CERTIFICATE

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DEATH	
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OR TOWN (If outside of town)	
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8. IS RESIDENCE  
ON A FARM?  
YES  NO  1966

Year  
2 1966

9. IF UNDER 24 HRS.  
Hours 2 Min. 0

10. NATURE OF WHAT  
DIED A.

11. TIME OF DEATH  
INTERVAL BETWEEN  
SET AND DEATH  
2 days

12. WAS AUTOPSY  
PERFORMED?  
YES  NO  1966

(State) Wash

13. SIGNATURE  
that (I) (we) last  
state stated above.  
SIGNED 2 1966

(State) and N. H.

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20M 1/65



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13061

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1D Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>1104 Parrish Drive</b>	
3. NAME OF DECEASED (Type or print) <b>WILBUR</b>		First <b>L.</b>	Middle <b>Van Pelt</b>
4. DATE OF DEATH <b>9 - 16 1966</b>	Month Year	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>1/5/14</b>
9. AGE (In years last birthday) <b>52 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George F. Van Pelt</b>		14. MOTHER'S MAIDEN NAME <b>Louise Mossefin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>477-30-7331</b>	
17. INFORMANT <b>Wilbur F. VanPelt - Item # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>adenocarcinoma of colon</i> DUE TO (c) <i>Peritonitis</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i> <i>3 months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/16/1966</b> to <b>9/16/1966</b> , that (I) (we) last saw the deceased alive on <b>9/16/1966</b> , and that death occurred at <b>4:50 P.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>2/17/66</b>	
22a. SIGNATURE <i>Stephen N. Jones</i>		22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>	
22d. ADDRESS <b>Rockville, Maryland</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMAT. ON. REMOVAL (Specify) <b>Bur-shipment 9/20/66</b>		23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM <b>Warren Cemetery</b>	
24. FUNERAL DIRECTOR <b>Tyson "heeler Funeral Home-1331 Rockville Pike</b>		ADDRESS <b>Rockville, Md.</b>	
25a. REC'D BY REGISTRAR <b>SEP 20 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
25c. DATE			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12008  
13062

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>99 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital, Bethesda, Maryland</b>		e. STREET ADDRESS <b>211 Prince Street</b>	
3. NAME OF DECEASED (Type or print) <b>Eleanore</b>		First <b>Eleanore</b>	Middle <b>Maria</b>
3. NAME OF DECEASED (Type or print) <b>Eleanore</b>		Last <b>VAN SWEARINGEN</b>	4. DATE OF DEATH <b>September 28 1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <b>WIDOWED</b>	8. NEVER MARRIED <b>Divorced</b>
9. a. DATE OF BIRTH <b>29 May 1904</b>		9. b. AGE (In years last birthday) <b>62 yrs</b>	
10a. JUSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artist/Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Philippine Islands</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Weston Percival Chamberlain</b>		14. MOTHER'S MAIDEN NAME <b>Eleanore Busch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Earl Kendall VAN SWEARINGEN</b>		18. ADDRESS <b>211 Prince St., Alexandria, Virginia</b>	
19. INTERVAL BETWEEN ONSET AND DEATH			
20a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesonephroma with massive metastases</b>			
1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>21 June 1966</b> to <b>28 September 1966</b> that <b>(X)</b> (we) last saw the deceased alive on <b>28 September 1966</b> , and that death occurred at <b>12:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Donald W. Cowherd</b>		22b. DATE SIGNED <b>30 Sept. 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald W. Cowherd, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/3/1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery, Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>John W. Murray</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 3 1966</b>	
Demaine Funeral Home, Alexandria, Virginia		25b. REGISTRAR'S SIGNATURE <b>John W. Murray</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

29

## CERTIFICATE OF DEATH

13063

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING @ 6MOS.		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Manor Health Care Center		d. STREET ADDRESS 304 Monroe St. Apt. 3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month Sept Day 9 Year 1966	
3. NAME OF DECEASED (First, Middle, Last) LORETTA R. VON CULIN		4. DATE OF DEATH Month Sept Day 9 Year 1966	
5. SEX Female White		6. COLOR OR RACE 7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED	
8. DATE-OF-BIRTH May 24, 1896		9. AGE (In years, months, days, or fraction of a year) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK - GSA		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.	
11. BIRTHPLACE (County & State, or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELON F. von CULIN		14. MOTHER'S MAIDEN NAME MARY LORETTA LLOYD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 577-16-7673	
17. INFORMANT DECEASED		Address	
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Organization</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Cerebrovascular</u> DUE TO (c) <u>Cerebral Aneurysm</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 22, 1966</u> to <u>Sept 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 8, 1966</u> , and that death occurred at <u>250</u> M. from causes and on the date stated above.		22b. DATE SIGNED <u>Sept 9, 1966</u>	
22a. SIGNATURE <u>Robert T. Thibadeau</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		22d. ADDRESS 11060 OLD GEORGETOWN RD., ROCHVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/13/1966	
23c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL		23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.	
24. FUNERAL DIRECTOR JAMES T. RYAN, INC., 301 W. PRESTON ST., WASH. 20003, D.C.		25a. RECEIVED BY REGISTRAR DATE SEP 13 1966	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 13064

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10310 Conover Drive</b>		d. STREET ADDRESS <b>7905 - 14th Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Joseph</b>		First <b>Robert</b>	Middle <b>Wallace</b>
4. DATE OF DEATH <b>September 8, 1966</b>	Month <b>September</b>	Day <b>8</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert C. Wallace</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ann White</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>7905 - 14th Avenue</b> 17. INFDRAINT <b>Address</b> <b>Robert C. Wallace, Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia and pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
9219 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration of gastric content</b>		Undet.	
DUE TO (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Probable viral infection</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>—</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	
20f. (City or town) <b>—</b> (County) <b>—</b> (State) <b>—</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>9/18/66</b>			
EXAMINER'S NAME (Type) <b>John S. Rogers, M.D.</b>		ADDRESS (Street, city, town, or county) <b>1919 Seminary Rd, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 9, 1966</b>	
23c. NAME OF CEMETERY OR CREATORIUM <b>St. John's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Forest Glen, Maryland</b>	
24. FUNERAL DIRECTOR <b>Clark &amp; Clark</b>		25a. REG'D. BY REGISTRAR <b>Warner E. Pumphrey, Inc.</b>	
25b. DATE <b>1966</b>		25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13065

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

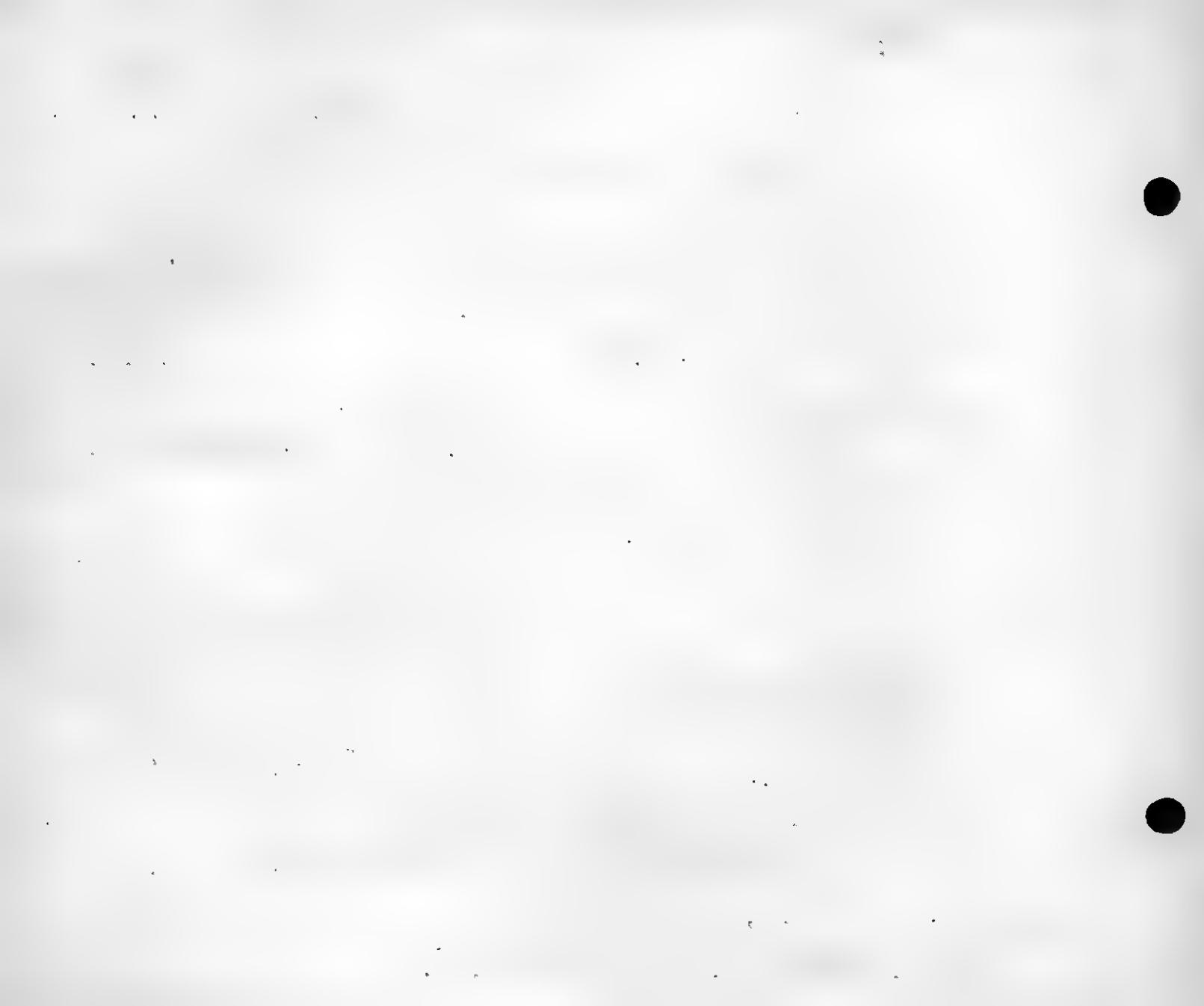
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 16 16 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RIVERMONT VALLEY NURSING HOME RIVERMONT VALLEY ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDITH		First MIDDLE	Last
4. DATE OF DEATH SEPT. 23 1966		Month	Day Year
S. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug 16, 1883		9. AGE (in years last birthday) 83 yrs.	
10a. USL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Parent		14. MOTHER'S MAIDEN NAME Kate Redford	
15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-62-0297 17. INFORMANT Grace Bulloch, Dtr., Same as #2	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Fecal occults</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b) <i>Rupture of diverticulum</i> 6 wks. DUE TO (c) <i>Debility and Colitis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteritis, atherosclerosis, Chronic Brain Syph</i>		INTERVAL, BETWEEN ONSET AND DEATH	
20d. ACCIDENT WAS UNDER, YING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or Town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 23, 1966</i> to <i>Sept 23, 1966</i> that (I) (we) last saw the deceased alive on <i>Sept 22, 1966</i> , and that death occurred on <i>Sept 23, 1966</i> from causes and on the date stated above.		22b. DATE SIGNED <i>9/23/66</i>	
22c. SIGNATURE <i>E. Herbert Bauersfeld</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>1912 R St. N.W. Wash. D.C.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/26/66	23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cem.
23d. LOCATION (City or Town) Washington, D.C.		(County) (State)	
24. FUNERAL DIRECTOR <i>Geo. Hawley Son, Washington, D.C.</i>		25a. REC'D BY REGISTRAR DATE SEP 27 1966	25b. REGISTRAR'S SIGNATURE <i>Geo. Hawley Son</i>



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			13066		
1. PLACE OF DEATH a. COUNTY			Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			a. STATE Maryland			b. COUNTY Montgomery		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Silver Spring			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Silver Spring					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			904 Laredo Road			13 years			d. STREET ADDRESS			904 Laredo Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year	September 21 1966					
5. SEX			6. COLOR DR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)			IF UNOER 1 YEAR	IF UNOER 24 HRS							
Female			White	WIDWED <input type="checkbox"/> DIVORCEO <input type="checkbox"/>	Oct. 17, 1875	90 yrs.			Months	Days	Hours						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS DR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?								
Housewife			Own Home			Ohio			U. S. A.								
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME														
Cyrus R. Runbaugh			Elizabeth Protsman														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			904 Laredo Rd.			Address			INTERVAL BETWEEN ONSET AND DEATH		
No			None			yes			LeRoy A. Wheeler			Silver Spring, Md.			2 wks.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cerebral thrombosis														
4 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			Arteriosclerotic cardiovascular disease														
DUE TO (b) DUE TO (c)			10 yrs.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
19																	
21. I certify that (I) (this hospital) attended the deceased from July 1956, to Sept. 21, 1966, that (I) (we) last saw the deceased alive on Sept. 21, 1966, and that death occurred at 12:30 AM, from the causes and on the date stated above.												22d. DATE SIGNED					
22a. SIGNATURE			Raymond Bradshaw,			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS			Sept. 21, 1966					
22c. PHYSICIAN'S NAME (Type)			Raymond Bradshaw						345 University Blvd., S. S., Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City, town or county) (State)								
Burial			Sep. 23, 1966			Cedar Hill Cemetery			Suitland, Maryland								
24. FUNERAL DIRECTOR			John B. Thomas, John B. Thomas, Warner E. Pumphrey, Inc.			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
						8434 Georgia Ave., Silver Spring, Md.			DATE SEP 27 1966			John B. Thomas, Warner E. Pumphrey, Inc.					



## MARYLAND STATE DEPARTMENT OF HEALTH

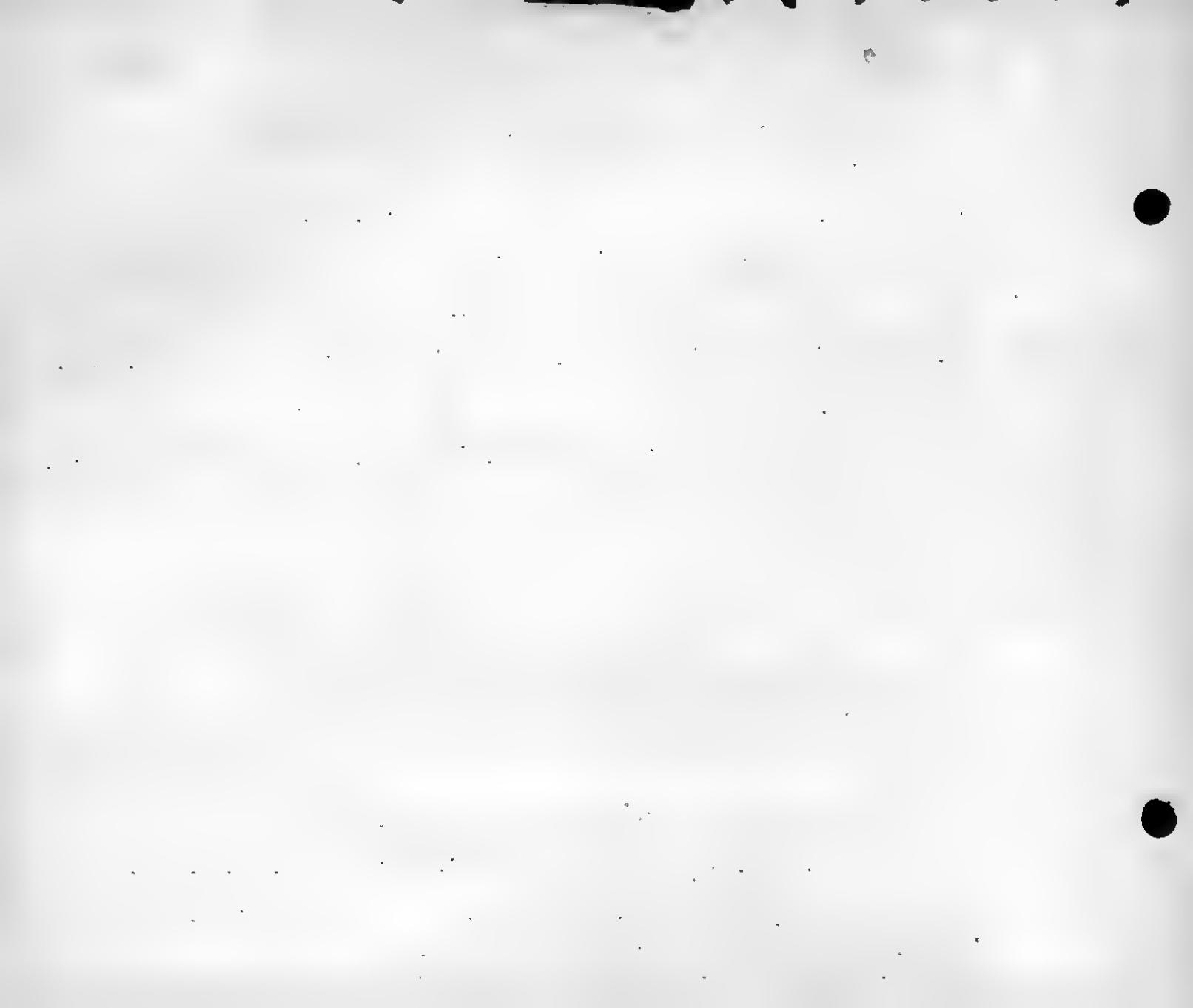
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13007

X  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
Montgomery Maryland		a. STATE b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		North Carolina Rowan				
Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Fairland Nursing Home		Salisbury				
3. NAME OF DECEASED (Type or print)		First	Middle			
Junius		Zed	Whirlow			
4. DATE OF DEATH		Month	Day			
September 8		1966				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
Male		White	WIOOWEO <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH				
Ret. Electrician		10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country)		9. AGE (In years last birthday)				
North Carolina		12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		U. S. A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.				
No		17. INFORMANT				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		515 Dennis Ave. Silver Spring, Md.				
150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS				
(b)						
DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19						
21. I certify that (i) (this hospital) attended the deceased from 7/7, 1966, to SEPT. 8, 1966, that (ii) (we) last saw the deceased alive on SEPT. 8, 1966, and that death occurred at 5:24 A.M. from the causes and on the date stated above.		22a. SIGNATURE James A. Roberts		22b. DATE SIGNED SEPT. 8, 1966		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 8907 Georgia Ave., S. S., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county) (State)		
Burial		Sep. 10, 1966	City Memorial Park	Salisbury, N. Carolina		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Clark E. Wisor		8434 Georgia Ave.		SEP 13 1966	James A. Roberts	
Warren E. Pumphrey, Inc.		Silver Spring, Md.				



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13068

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Rockville		Montgomery	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
8 years		Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
13117 Dunbarton Drive		13117 Dunbarton Drive	
e. IS RESIDENCE ON A FARM?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Frank		Ernest Williams	
4. DATE OF DEATH		Month	Day Year
Sept		12	1966
5. SEX		6. COLOR OR RACE	7. MARRIED
Male		White	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min
8-21-22		44 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State or foreign country)	
Geodesist		U.S. Govt. Monona, Iowa	
12. CITIZEN OF WHAT COUNTRY?			
USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Harry O. Williams		Lenore Hogue	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
No None		482-16-1878	
17. INFORMANT		Gwen H. Williams Address as above #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 16-1		Brochopneumonia few days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Brochogenic Carcinoma 8 mos.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1966, to 9/12 1966, that (I) (we) last saw the deceased alive on 9/9 1966, and that death occurred at 9:30P M, from causes and on the date stated above.		22b. DATE SIGNED 9/12/66	
22a. SIGNATURE G. Leonard Gold		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) G. Leonard Gold		22d. ADDRESS 8641 Colesville Rd., S. S., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sep. 17, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Blencoe Cemetery		23d. LOCATION (City or Town) (County) (State) Blencoe, Iowa	
24. FUNERAL DIRECTOR C. Glen Carter 816-7484 8434 Georgia Ave. Warren E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR DATE SEP 15 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13069

PLACE OF DEATH

a. COUNTY

*Montgomery*

MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)

*Takoma Park*

c. LENGTH OF STAY IN lb

*48 hrs*

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE

*Maryland*

b. COUNTY

*Montgomery*

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

*Wash. SAN. FARMERS Hospital*

d. STREET ADDRESS

*7812 Boston Ave*

e. IS RESIDENCE  
ON A FARM?

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First  
*IDA*

Middle  
*MAE*

Last  
*Wilson*

4. DATE  
OF  
DEATH

Month  
*September* Day  
*16* Year  
*1966*

5. SEX

FEMALE

6. COLOR OR RACE  
*White*

7. MARRIED  
 NEVER MARRIED  
 WIDOWED  
 DIVORCED

8. DATE OF BIRTH

*11-25-08*

9. AGE (In years  
at birthday)  
yrs

10. IF UNDER 1 YEAR  
Months  
Days  
Hours  
Min

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

*Housewife*

10b. KIND OF BUSINESS OR  
INDUSTRY

*Absent Own Home*

11. BIRTHPLACE (County & State, or foreign country)

*D.C. - Wash.*

12. CITIZEN OF WHAT  
COUNTRY?  
*USA*

13. FATHER'S NAME

*PATRICK Gleason*

14. MOTHER'S MAIDEN NAME

*NETTIE Wilburn*

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

*577-03-1318*

17. INFORMANT

*Wm. E. Wilson* *1812 Boston Ave.*  
*Exxon* *Silver Spring, Md.*

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Conditions, if any, which gave  
rise to immediate cause (a),  
stating the underlying cause

lost

DUE TO

*Cardiac Arrest*

INTERVAL BETWEEN  
ONSET AND DEATH

*Immediate*

(b)

*Congestive Heart Failure*

Weeks

DUE TO

(c)

*Arteriosclerotic Heart Disease*

Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m.

20d. INJURY OCCURRED  
While  
Not While  
of work  of work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg, etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from *9-14*, 19*66*, to *9-16*, 19*66*, that (I) (we) last  
saw the deceased alive on *9-16*, 19*66*, and that death occurred at *10:25 AM*, from causes and on the date stated above.

22a. SIGNATURE

*Stuart L. Nelson*

M.D. ATTENDING  
PHYS.  MED  
DIRECTOR  STAFF  
PHYS.

22b. DATE SIGNED  
*9-16-66*

22c. PHYSICIAN'S  
NAME (Type)

*Stuart L. Nelson*

22d. ADDRESS

*831 University Blvd., E., S. S., Md.*

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City or Town) (County) (State)

*Burial*

*Sep. 20, 1966*

*Fort Lincoln Cemetery*

*Prince Georges Co., Md.*

24. FUNERAL DIRECTOR

*C. Glen Carter*

ADDRESS

*8434 Georgia Ave.*

25a. REC'D BY REGISTRAR

*25b. REGISTRAR'S SIGNATURE*

*Warren E. Pumphrey, Inc.*

*Silver Spring, Md.*

*Silver Spring*

*SEP 27 1966*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
12-76  
1  
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for us as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13070

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>			c. LENGTH OF STAY IN 16 <i>18 h - 45 m</i>			
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>HOLY CROSS</i>			d. STREET ADDRESS <i>2821 Hathaway TERRACE</i>			
3. NAME OF DECEASED (Type or print) <i>Andrienne</i>			First <i>Andrienne</i>	Middle <i></i>	Last <i>Wodicka</i>	
4. DATE OF DEATH <i>9 16 66</i>	Month <i>9</i>	Day <i>16</i>	Year <i>1966</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>9/15/66</i>	9. AGE (In years last birthday) yrs. <i>9</i>	10. IF UNDER 1 YEAR Months <i>18</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i></i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery - Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i></i>		11. IF UNDER 24 HRS. Days <i>45</i>	
13. FATHER'S NAME <i>Richard Edward Wodicka</i>	14. MOTHER'S MAIDEN NAME <i>Barbara Jeanne Fasic</i>	15. ADDRESS <i>Mother</i>				
16. SOCIAL SECURITY NO <i></i>	17. INFORMANT <i>Mother</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Chronic Hemispheric Disease of the brain</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>18 mos</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i></i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i></i>	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <i></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State) <i>9116 1966 1966</i>
21. I certify that (I) (this hospital) attended the deceased from <i>9/15</i> , 1966, to <i>9/16</i> , 1966, that (I) (we) last saw the deceased alive on <i>9/15</i> , 1966, and that death occurred at <i>M</i> , from causes and on the date stated above.	22a. SIGNATURE <i>Richard Fasic</i>	22b. DATE SIGNED <i>9/16/66</i>				
22c. PHYSICIAN'S NAME (Type) <i></i>	22d. ADDRESS <i></i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i></i>	23b. DATE THEREOF <i>9-17-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. John's Forest Glen</i>	23d. LOCATION (City or Town) (County) (State) <i>Silver Spring</i>			
24. FUNERAL DIRECTOR <i>Thos. B. Fasic 4748 - 04166</i>	25a. RECEIVED BY REGISTRAR <i></i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	25c. DATE SEP 20 1966			



13071

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>Wash. San + Hospital</i>		2 USUAL RESIDENCE (Where deceased resided, if institution, residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>John</i>		d. STREET ADDRESS <i>Silver Spring</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		e. DATE OF DEATH Month <i>9</i> Day <i>28</i> Year <i>1966</i>			
3 NAME OF DECEASED (Type or print)	First <i>Hillery</i>	Middle <i>Young</i>	Last <i>John</i>	4 DATE OF DEATH	Month <i>9</i>	Day <i>28</i>	Year <i>1966</i>		
5 SEX <i>male</i>	6 COLOR OR RACE <i>negro</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/2/17</i>	9. AGE (in years last birthday) <i>49</i> yrs	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>1</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>1</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Leslie Columbus Young</i>		14. MOTHER'S MAIDEN NAME <i>Emma Jackson</i>		15. SOCIAL SECURITY NO.		16. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia, cause undetermined</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)								19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>								22. DATE SIGNED <i>9-29-1966</i>	
ACTUAL SIGNATURE <i>Belden Chapel M.D.</i> EXAMINER'S NAME (Type) <i>BELODEN R. CHAP. M.D.</i>								CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>AIRIAL</i>		23b. DATE THEREOF <i>10/4/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>		23d. LOCATION (City or Town) (County) (State) <i>Huntington, D.C.</i>			
24. FUNERAL DIRECTOR <i>Robert L. Saarinen Rockville, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Oct 6 1966</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

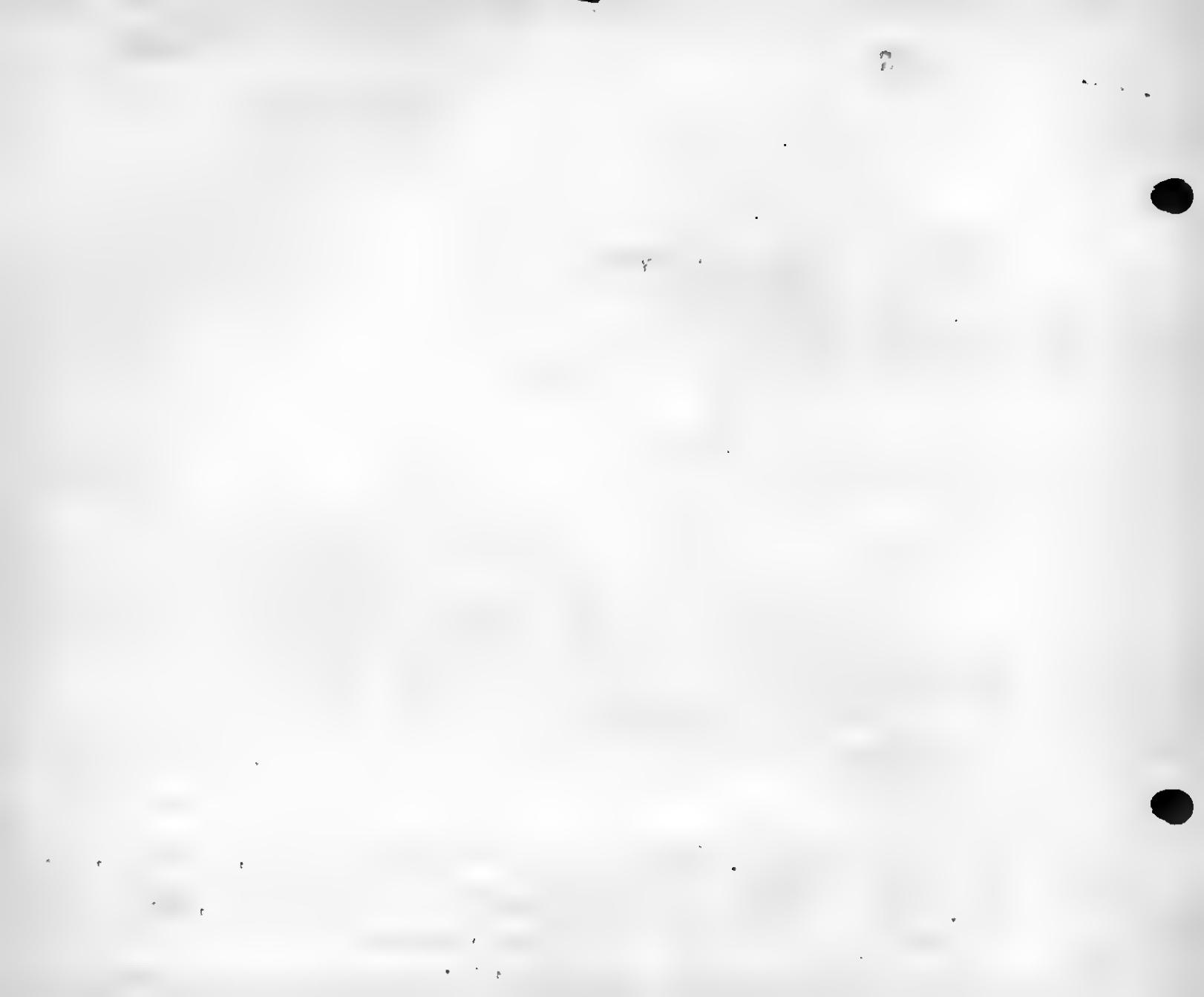
## CERTIFICATE OF DEATH

13072

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
<i>Maryland</i> MARYLAND		<i>Minn.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>See File side 2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Minneapolis</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Tu berculosis</i>		d. STREET ADDRESS <i>5015 - 15th, N.W.</i>	
e. LENGTH OF STAY IN b <i>2 days</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) KING HENRY		4. DATE OF DEATH Month Day Year Sept. 12 1966	
5 SEX <i>Male</i>		6 COLOR OR RACE <i>White</i>	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <i>July 13 1892</i>		10. AGE (In years lost bushay) <i>74 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Film Director</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Michigan</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Young</i>		14. MOTHER'S MAIDEN NAME <i>Morris</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <i>545-01-1615</i>	
17. INFORMANT <i>Mrs. Charles Morris</i>		Address <i>1101 St. Louis</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>		INTERVA. BETWEEN ONSET AND DEATH <i>1 hr</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Myocardial Infarction</i>		72 hr	
DUE TO <i>Coronary Thrombosis</i>		72 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Full Employment</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>9/12/66</i> , and that death occurred at <i>6:00 AM</i> from causes and on the date stated above.		22b. DATE SIGNED <i>9/12/66</i>	
22a. SIGNATURE <i>Stephen N. Jones</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Stephen N. Jones</i>		22d. ADDRESS <i>809 Veirs Mill Road, Rockville, Md.</i>	
23a. BURIAL, CREMATION, BURIAL <i>Bury</i>		23b. DATE THEREOF <i>9/16/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Hillside Cemetery</i>		23d. LOCATION (City or Town) <i>Minneapolis, Minnesota</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		25a. ADDRESS <i>1931 Rockville Pike</i>	
		25b. DATE BY REGISTRAR <i>Rockville, Md.</i>	
		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13073

1. PLACE OF DEATH a. COUNTY		Items 3, 11 Film 6380 9/11/66		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
Montgomery		MARYLAND		a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Montgomery							
Silver Spring		18 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Silver Spring		d. STREET ADDRESS							
705 Bonifant Street		705 Bonifant Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH						
Louise		L.	F.	Young	September 8 1966						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years) IF UNDER 1 YEAR						
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 8, 1907	59 yrs. Months Days Hours Min.						
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KNO OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)							
Secretary		May Hardware Company		Somerset City, Md.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY							
Jasiah W. Pollitt		Margaret Hayman		U.S.A.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT							
No		577-70-8286		Minnie Jones 10016 Brunell Avenue Silver Spring, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		9030 <i>Myocardial collage &amp; Cys. heart failure</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <i>beginning to move in neck.</i> DUE TO (c) <i>shortness of breath &amp; pain in chest</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		2. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> p.m. Sept 8 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20g. <i>fall on top of person in bed</i>		20h. <i>fall on top of person in bed</i>		20i. <i>fall on top of person in bed</i>		20j. <i>fall on top of person in bed</i>		20k. <i>fall on top of person in bed</i>		20l. <i>fall on top of person in bed</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED									
ACTUAL SIGNATURE <i>John S. Rogers</i>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) John S. Rogers		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
1919 Seminary Rd. Silver Spring, Md.		Address (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 11, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Allen Cemetery		23d. LOCATION (City, town or county) Allen, Maryland					
24. FUNERAL DIRECTOR Clark E. Wilson		ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc.		Silver Spring, Md.		DATE SEP 14 1966		Charles Judge					

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13080

## CERTIFICATE OF DEATH

13074

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~fill in~~ carbon papers. Pages 1 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>			c. LENGTH OF STAY IN 1b <b>4 yrs. 5 mos.</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>			d. STREET ADDRESS <b>4329 LELAND ST.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL HALL SANITARIUM</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>HATTIE</b>	Middle <b>E.</b>	Last <b>ZELLERS</b>	4. DATE OF DEATH <b>SEPT. 10 1966</b>
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-4-1883</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR <b>1 Months</b>		11. IF UNDER 24 HRS. <b>6 Days</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BROOKLYN, NEW YORK</b>	
13. FATHER'S NAME <b>SAMUEL F. EDWARDS</b>			14. MOTHER'S MAIDEN NAME <b>PAULINE FREEMAN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-52-7601</b>		17. INFORMANT <b>MRS. BESSIE ALLISON</b>	
Address <b>4329 Lehandst CHEVY CHASE, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Diabetes mellitus</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>NO</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>No</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.) <b>Topant</b>	
21. I certify that (I) (This hospital) attended the deceased from <b>1952</b> , 19 to <b>Sept 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 6, 1966</b> , and that death occurred at <b>2 p.m.</b> from causes and on the date stated above.					
22e. SIGNATURE <b>John B. Umhau</b>		FOR DR. <b>John B. Umhau</b> , M.D.		22b. DATE SIGNED <b>9/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. UMHAU, M.D.</b>		22d. ADDRESS <b>8805 CONN. AVE. CHEVY CHASE MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-12-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>ROCK CREEK</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, BETHESDA, MD.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>SEP 14 1966</b>			

